

FOR STATE
HEALTH DEPT

M

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

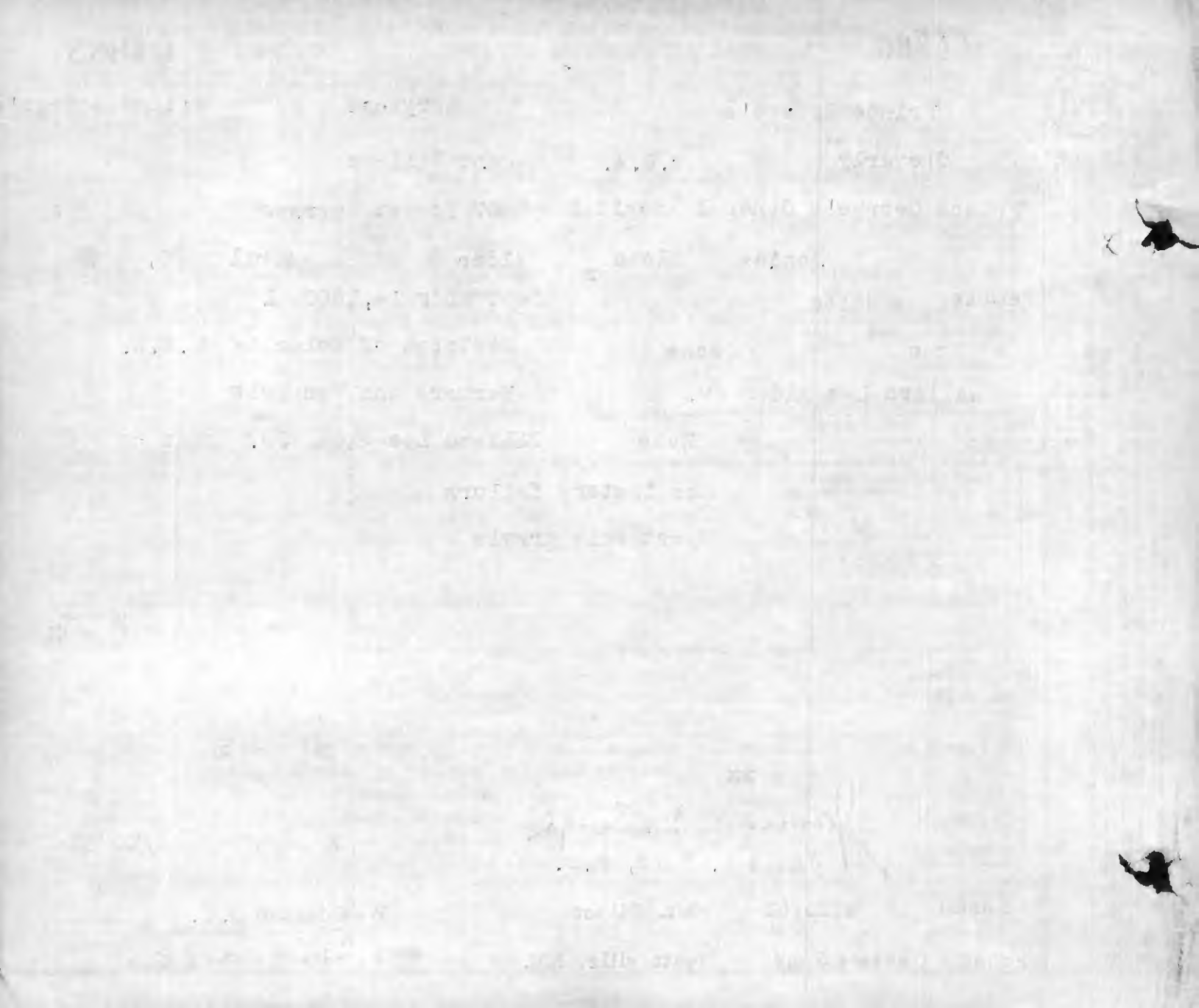
04866

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04865

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kent Village	
c. LENGTH OF STAY IN TB D.O.A.		d. STREET ADDRESS 2807 Forest Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Monica Middle Rose Last Alder		4. DATE OF DEATH Month April Day 20 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1960	
9. AGE (in years last birthday) 1		10. IF UNDER 1 YEAR Months 1 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 1		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willard Lee Alder Jr.		14. MOTHER'S MAIDEN NAME Barbara Ann Van Pelt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Willard Lee Alder Jr.		Address same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myasthenia gravis (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/20/62	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/62	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or country) (State) Washington D. C.	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR APR 24 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel	



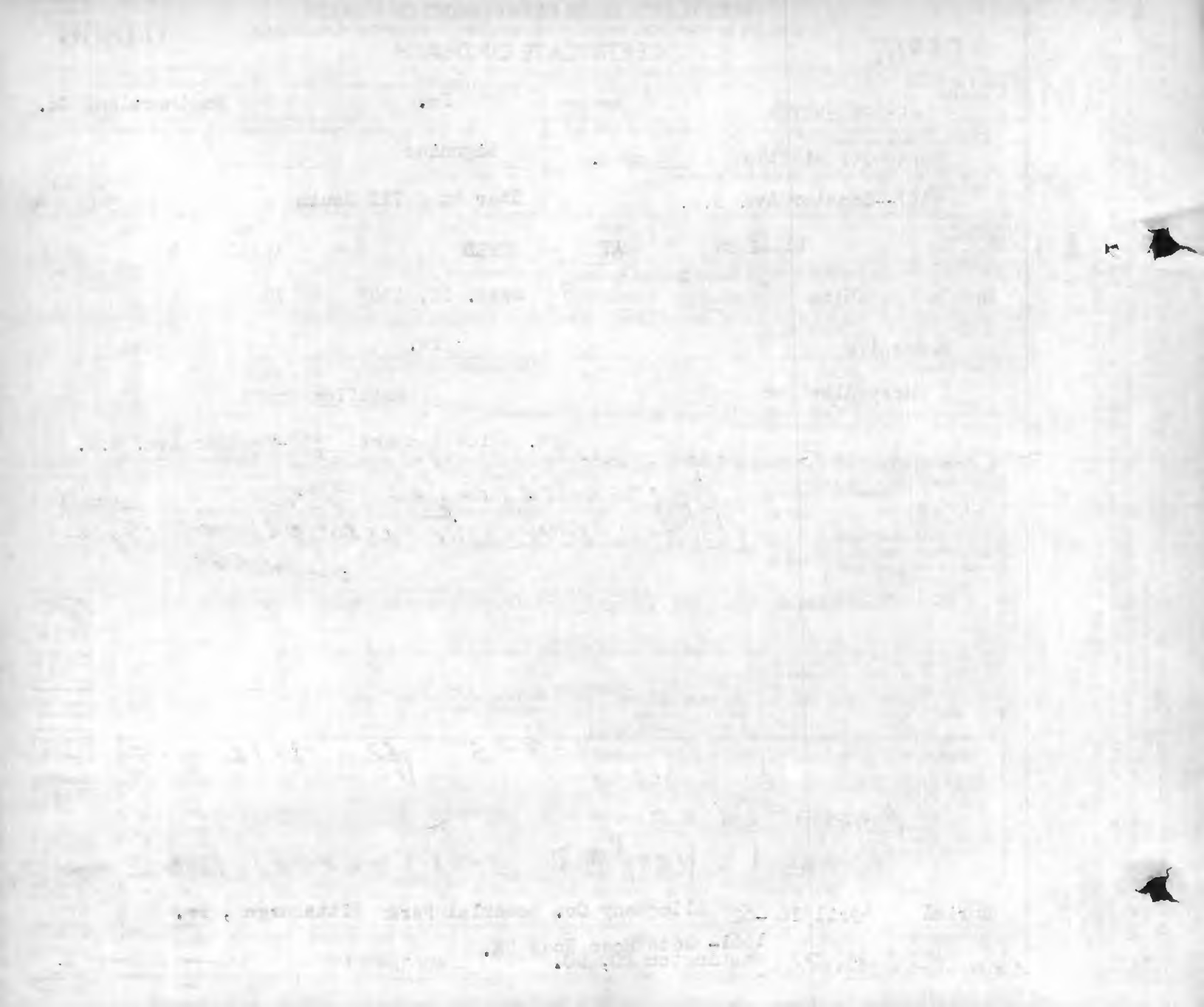
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04867

04866

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Westmoreland Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville			c. LENGTH OF STAY IN 1b 6 mons.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ligonier			75x-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3337--Senator Ave. S.E.				d. STREET ADDRESS Star Rt # 711 South			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAY Last APPEL			4. DATE OF DEATH Month April Day 12 Year 1962				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1883		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Albright				14. MOTHER'S MAIDEN NAME Mathilda Groat			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Alice Lammert 3337-Senator Ave. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Can condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day 15 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-5 19 62 to 4-12 19 62 that (I) (we) last saw the deceased alive on 4-10 19 62 and that death occurred at 1P M, from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Cleary				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cleary M.D.				22d. ADDRESS 5558 Silver Hill Rd. District Heights, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16 -62		23c. NAME OF CEMETERY OR CREMATORY Alleghany Co. Memorial Park		23d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Summers Brother				1661- Good Hope Road SE. Washington 20, D.C.		25a. REC'D BY REGISTRAR DATE APR 16 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04868

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04867

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennelworth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Kennelworth	
c. LENGTH OF STAY IN 1b 12 yrs		d. STREET ADDRESS 1607 Eastern Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1607 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexious A. Baker		4. DATE OF DEATH April 9 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1886	
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days 19 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Fannie Prosperi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Grace Webb Bulloch, 3009 -37th. St., N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial insufficiency (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/62	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR W.W. Chambers Co.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Hume	
24c. ADDRESS Riverdale, Maryland		24d. DATE APR 17 '62	

MEDICAL CERTIFICATION

1
FOR STATE HEALTH DEPT. **M**

2
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, play as execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3
MEDICAL CERTIFICATION

4
2

5
VR A15ME
5M 1/62

6
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8
04868

9
1. PLACE OF DEATH
a. COUNTY **Prince George's** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN b. **D.O.A.**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Prince George's General Hospital**

10
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Prince George's**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Hyattsville**
d. STREET ADDRESS **3402 54th., Avenue**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

11
3. NAME OF DECEASED (Type or print) **Charles Moncure Barlow**
4. DATE OF DEATH **April 16, 1962**
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Dec. 11, 1920** 9. AGE (In years last birthday) **41** yrs. IF UNDER 1 YEAR: Months ☐ Days ☐ IF UNDER 24 HRS.: Hours ☐ Min. ☐

12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **S.P. 5** 10b. KIND OF BUSINESS OR INDUSTRY **U.S. Army** 11. BIRTHPLACE (State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13
13. FATHER'S NAME **Charles Moncure Barlow** 14. MOTHER'S MAIDEN NAME **Romero**

14
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **yes** 16. SOCIAL SECURITY NO. **1943 - 1962 230-03-6950** 17. INFORMANT **Helen Martha Barlow** Address **Same as #2**

15
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Acute occlusion of Coronary Artery**
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) **HEMORRHAGE IN ATHEROMATOUS PLAQUE**
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

16
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

17
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

18
ACTUAL SIGNATURE **James I. Boyd** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **JAMES I. BOYD, M.D.** ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **4/16/62**
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

19
22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **4/19/62** 22c. NAME OF CEMETERY OR CREMATORY **Arlington Mt. Arlington, Va.** 22d. LOCATION (City, town, or country) (State)

20
23. FUNERAL DIRECTOR **W.W. Chambers Co. Washington, D.C.** ADDRESS **Washington, D.C.** 24a. REC'D BY REGISTRAR **APR 18 '62** 24b. REGISTRAR'S SIGNATURE **Arthur S. Krause**

01965

01965

Prince George's

Norfolk

Prince George's

Stettinville

Q. 4

Curry

3402 Main, Avenue

Prince George's General Hospital

68

10

April

Follow

Monroe

Charles

at

Dec. 13, 1950

White

Male

U.S.A.

Virginia

U.S. Army

S.I. 5

George

Charles Monroe Harvey

Case no 42

1947 - 1952 210-07-530 John Martin Berlin

Part of the Confidential Army
Memorandum in Washington, D.C.

X

James J. Boyd, M.D.

1/25/60

FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18 & 21, File G-512 5/7/62.cac.

04870

04869

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 4489 Brooks Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Barth			
4. DATE OF DEATH Month Day Year April 28, 1962			
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1917	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistance Manager Peoples Drug		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Barth		14. MOTHER'S MAIDEN NAME Lillian Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 136-05-3363	
17. INFORMANT Jean Hess Barth		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (PENDING) Acute hemorrhagic necrosis of gastro intestinal tract. 971.3 Conditions, if any, which gave rise to immediate cause (b) Ingestion of ammonium hydroxide DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Grand Mal Epilepsy			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined/Indefinite			
ACTUAL SIGNATURE Paul A. Van Natta		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul Van Natta, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/28/62	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1962	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR 1661--Good Hope Rd., SE Washington 20, DC		24a. REC'D BY REGISTRAR MAY 1 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

MEDICAL CERTIFICATION

05830

(M)

(BANKS)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04871

CERTIFICATE OF DEATH

04870

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 Min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 23C Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph A. Bartholomew 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-16-12 9. AGE (In years last birthday) <input checked="" type="checkbox"/> 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month Day Year April 25, 19 62 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Specialist 10b. KIND OF BUSINESS OR INDUSTRY U S Government 11. BIRTHPLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Theodore R Bartholomew 14. MOTHER'S MAIDEN NAME Anna E Dross 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 17. INFORMANT Doris L. Bartholomew Greenbelt, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bilateral Pulmonary congestion DUE TO (b) Arteriosclerotic Heart Disease + Coronary Thrombosis - 12 yrs. (a), stating the underlying cause last. DUE TO (c) Cardiac Failure 6 wks PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 25, 1962, to April 25, 1962 that (I) (we) last saw the deceased alive on April 25, 62 and that death occurred at 9:45 P.M. the causes and on the date stated above. 22a. SIGNATURE Albert Roth M.D. 22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5510 Madison St., Riverdale, Md. 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 23b. DATE THEREOF 4/26/62 23c. NAME OF CEMETERY OR CREMATORY Centerville 23d. LOCATION (City, town or county) (State) Iowa			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. ADDRESS 25a. REC'D BY REGISTRAR DATE APR 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT. M
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Page 1, 2, and 3 to the funeral director. Page 4, 5, and 6 to the State Department of Health. Page 7 may be retained for your files. Page 8 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 9 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04871

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 8 Delano Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle John Last Bartz Sr.		4. DATE OF DEATH Month April Day 8th. Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1912	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile setter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Frederick Bartz		14. MOTHER'S MAIDEN NAME Catherine Sagorski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 579-18-7052	
17. INFORMANT Irene Ethel Bartz, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute congestive heart failure			
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease			
(c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11-62	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town or country) (State) Bladensburg Md	
23. FUNERAL DIRECTOR Summers Bros.		24a. REC'D BY REGISTRAR APR 11 '62	
1661- Good Hope Rd SE WASH 20 DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

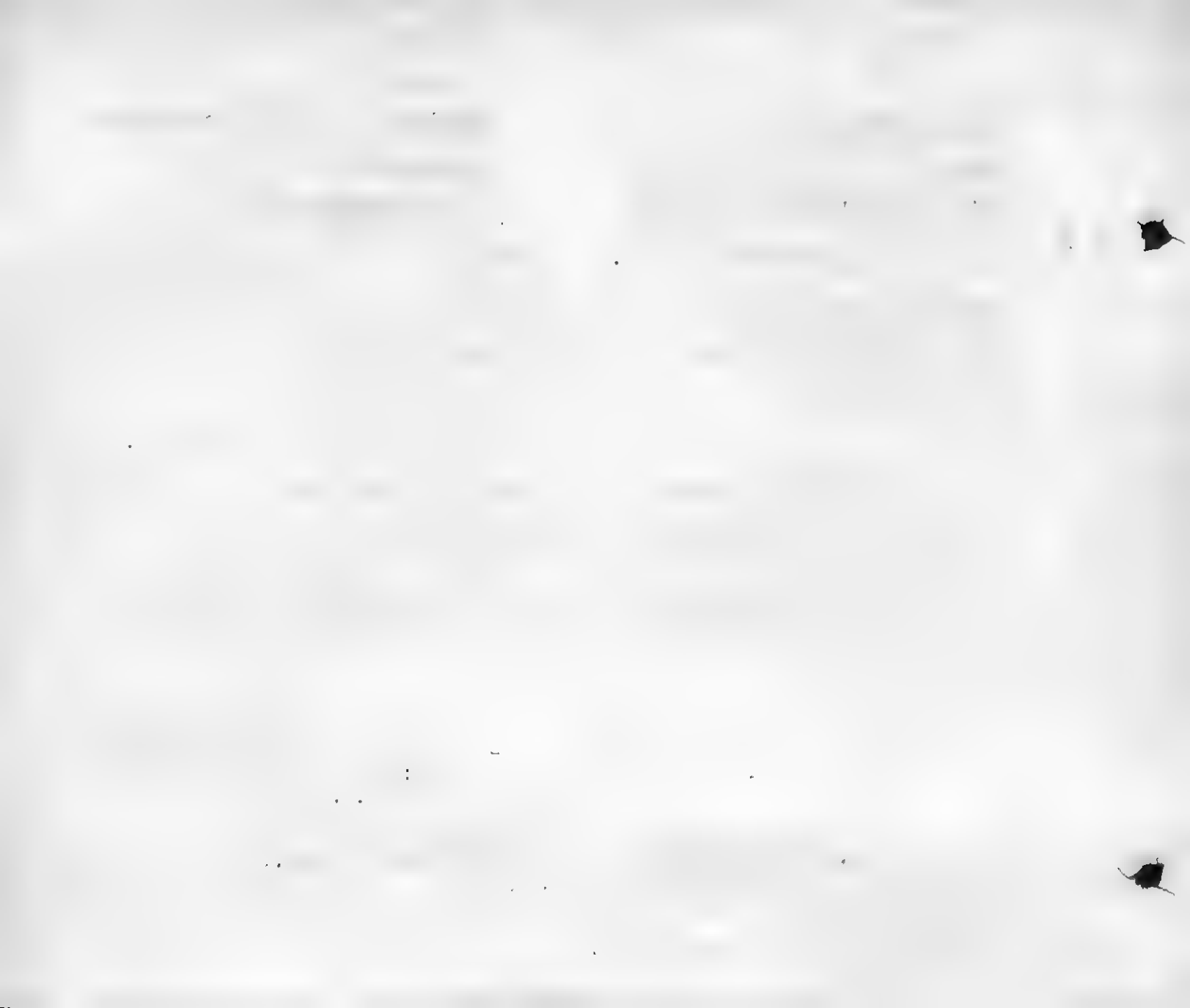
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04873

CERTIFICATE OF DEATH

04872

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6703 Redfield Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy I. Beaver		4. DATE OF DEATH Month Day Year April 30 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-83	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Claude Marion		14. MOTHER'S MAIDEN NAME Marinda Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records Cheverly Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrosis of left cerebellar hemisphere 332 X DUE TO Conditions if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-23 19 62 to 4-30 19 62 that (I) (we) last saw the deceased alive on 4-30 19 62 , and that death occurred 9:40 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Hei K. Lee M.D.		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Hei Kit Lee		22d. ADDRESS 7730 Annapolis Road, Lanham, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962	
23c. NAME OF CEMETERY OR CRYPTORY U S Soldiers Home Cemetery		23d. LOCATION (City, town or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR MAY 4 '62	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

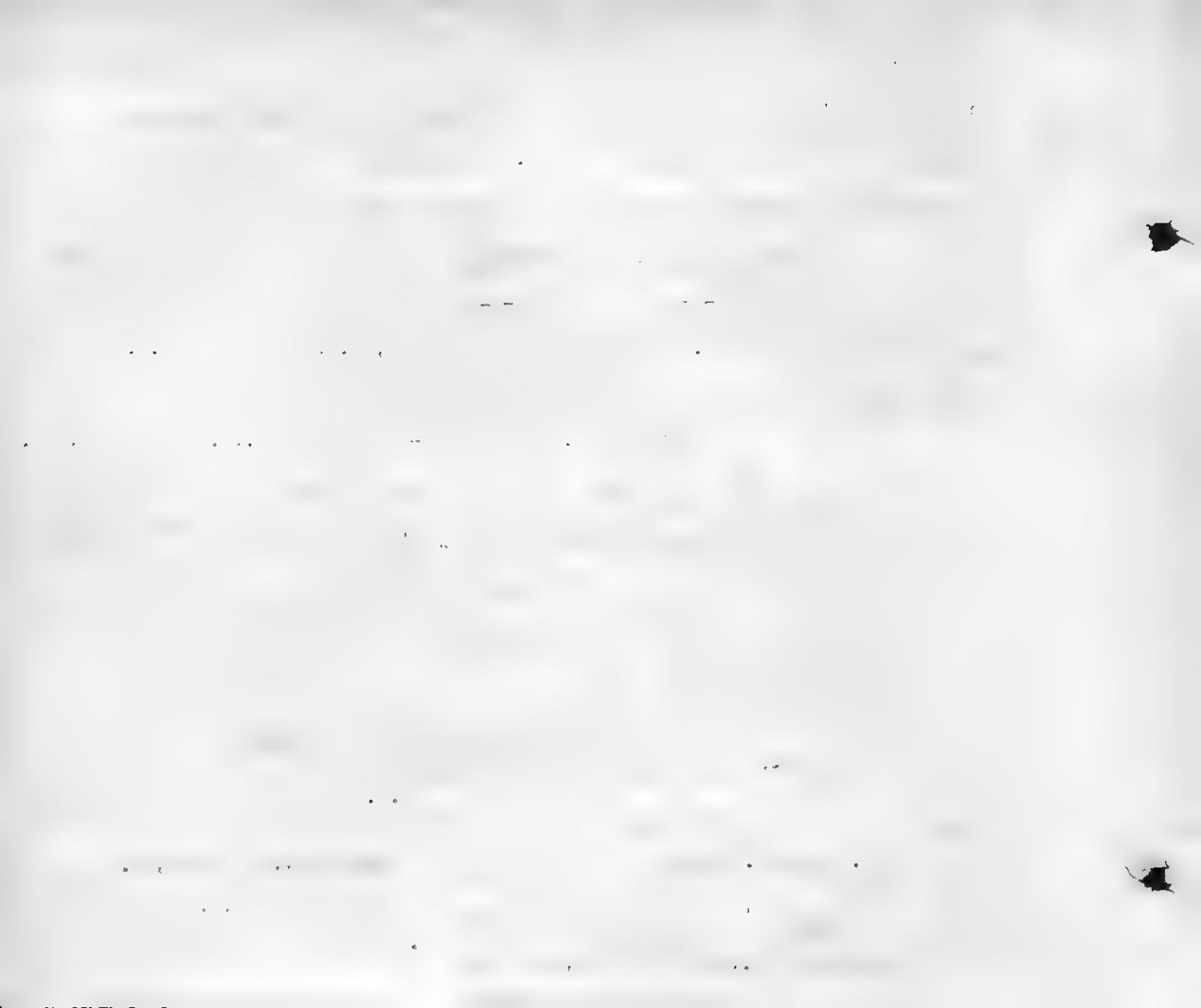
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04874

04873

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 6100 Ager Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene E. Behrend		4. DATE OF DEATH Month Day Year April 26 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-78
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days 27 days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Uriha Behrend		14. MOTHER'S MAIDEN NAME Frances Etting	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) None		16. SOCIAL SECURITY NO. 579-54-7889	
17. INFORMANT J. Norman Ager - 6100 Ager Rd., W. Hyattsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis with Uremia 5-4-0 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Perforated gastric ulcer, post-surgical status } 27 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/26/62 to 4/26/62 , that (I) (we) last saw the deceased alive on 4/26/62 , and that death occurred at 11:00 from the causes and on the date stated above.			
22a. SIGNATURE David S. Clayman M.D.		22b. ADDRESS 6311 Baltimore Ave., Riverdale, Md.	
22c. PHYSICIAN'S NAME (Type) Dr. David S. Clayman		22d. LOCATION (City, town or county) (State) Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-30-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska Warner E. Pumphrey, Inc., Silver Spring, Maryland		25a. REC'D BY REGISTRAR DATE APR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. DATE APR 30 '62	



04875

CERTIFICATE OF DEATH

04874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE MARYLAND b COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 10 years.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6313-Livingston Rd. S.E.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
f. STREET ADDRESS 6313-LIVINGSTON Road.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN BRISCOE BELL		4. DATE OF DEATH Month APRIL Day 2 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY. 1. 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 8 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL (Md)	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME CHARLES DAVID BELL		14. MOTHER'S MAIDEN NAME Clara W. STEPHENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO 579-03-2825	
17. INFORMANT Clarence M. BELL (brother)		Address WARSAW, VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LUNGS. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			
INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from MAY 19 62 , to APRIL 19 62 , that I last saw the deceased alive on MARCH 31 19 62 , and that death occurred at 7:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3800 E. Capitol St. Wash. 20 D.C. DATE SIGNED 4/2/62 ACTUAL SIGNATURE Max E. Feldman M.D. PHYSICIAN'S NAME (Type) MAX E. FELDMAN M.D. Maryland Registration No. A 3874			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 4-62	22c. NAME OF CEMETERY OR CREMATORY Burial by church	22d. LOCATION (City, town, or county) (State) Warshaw, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR DATE APR 5 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Kiser

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04876

04875

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D. C. b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland, Maryland d. STREET ADDRESS Homer 4706 XXXXXX Ave., S. E. (Suitland) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine First Middle Last Female White WIDOWED DIVORCED		4. DATE OF DEATH April 26 1962 Month Day Year 10-16-82 1962 B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) 79 Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Domestic 11. PLACE (County & State, or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ignatius Lubo 14. MOTHER'S MAIDEN NAME Anna ? 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Nicholas P. Bellavin Address Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized peritonitis DUE TO Multiple perforations of descending colon (b) Intestinal Obstruction (c) Carcinoma of the Sigmoid Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/18 1962 to 4/26 1962 that (I) (we) last saw the deceased alive on 4/26 1962, and that death occurred 11:05, from the causes and on the date stated above. 22a. SIGNATURE <i>Hei K. Lee</i> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. Hei Kit Lee 22d. ADDRESS 7730 Annapolis Rd., Lanham, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Burial May 1 - 62 Washington National Suitland, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Summons Bros 1666 2000 York</i> DATE APR 30 '62 <i>William L. Hume</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04877

04876

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 6007 41st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Francis B.F. Benton				4. DATE OF DEATH Month Day Year April 17 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1913	9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Benton			14. MOTHER'S MAIDEN NAME Anna Lipska				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none	17. INFORMANT Mrs Bonnie C. Benton		Address Wife as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19<u>62</u> to <u>4/17</u> 19<u>62</u> that (I) (we) last saw the deceased alive on <u>4/16</u> 19<u>62</u>, and that death occurred at <u>6:45 A.M.</u> the causes and on the date stated above.							
22a. SIGNATURE Max M. Herzberg			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED April 17, '62		
22c. PHYSICIAN'S NAME (Type) Dr. M. Herzberg			22d. ADDRESS 7016 Greig St., Seat Pleasant, Md.				
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 4/20/1962	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmarmanor Md.			
24. FUNERAL HOME Lee Funeral Home			25a. REC'D BY REGISTRAR DATE APR 23 '62	25b. REGISTRAR'S SIGNATURE James S. Thomas			

MEDICAL CERTIFICATION

TO HOW FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04878 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04877

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham	
c. LENGTH OF STAY IN 1b 23 months		d. STREET ADDRESS 347 Cipriano Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 347 Cipriano Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Eugene Berger		4. DATE OF DEATH Month Day Year April 1 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1899 62s	
9. AGE (In years last birthday) 62s		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Robert Berger		14. MOTHER'S MAIDEN NAME Unknown - Lola Frye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO 578 24 4278	
17. INFORMANT Virginia Davis Berger, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) DUE TO Coronary arteriosclerotic heart disease (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/62	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or country) (State) 'Bladensburg Maryland	
23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

04879 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04878

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not put on Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 - 57th. Avenue		d. STREET ADDRESS 420 - 57th. Avenue	
3. NAME OF DECEASED (Type or print) George Washington Blake		4. DATE OF DEATH April 23, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 27, 1897		9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS 65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Blake		14. MOTHER'S MAIDEN NAME Ida Elizabeth Lovejoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-034075	
17. INFORMANT Mrs. Dora Barnett; Capitol Hgts. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Disease (Arteriosclerosis) DUE TO General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial Asthma (Emphysema)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Natural Causes	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Natural Causes	
20f. (City or town) Suitland		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul C. VanNatta		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Paul C. VanNatta		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27-1962	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or country) Suitland, Md.	
23. FUNERAL DIRECTOR W. W. Chambers Co - Pasadena, Md.		24a. REC'D BY REGISTRAR APR 30 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Knapp		DATE SIGNED April 23, 1962	

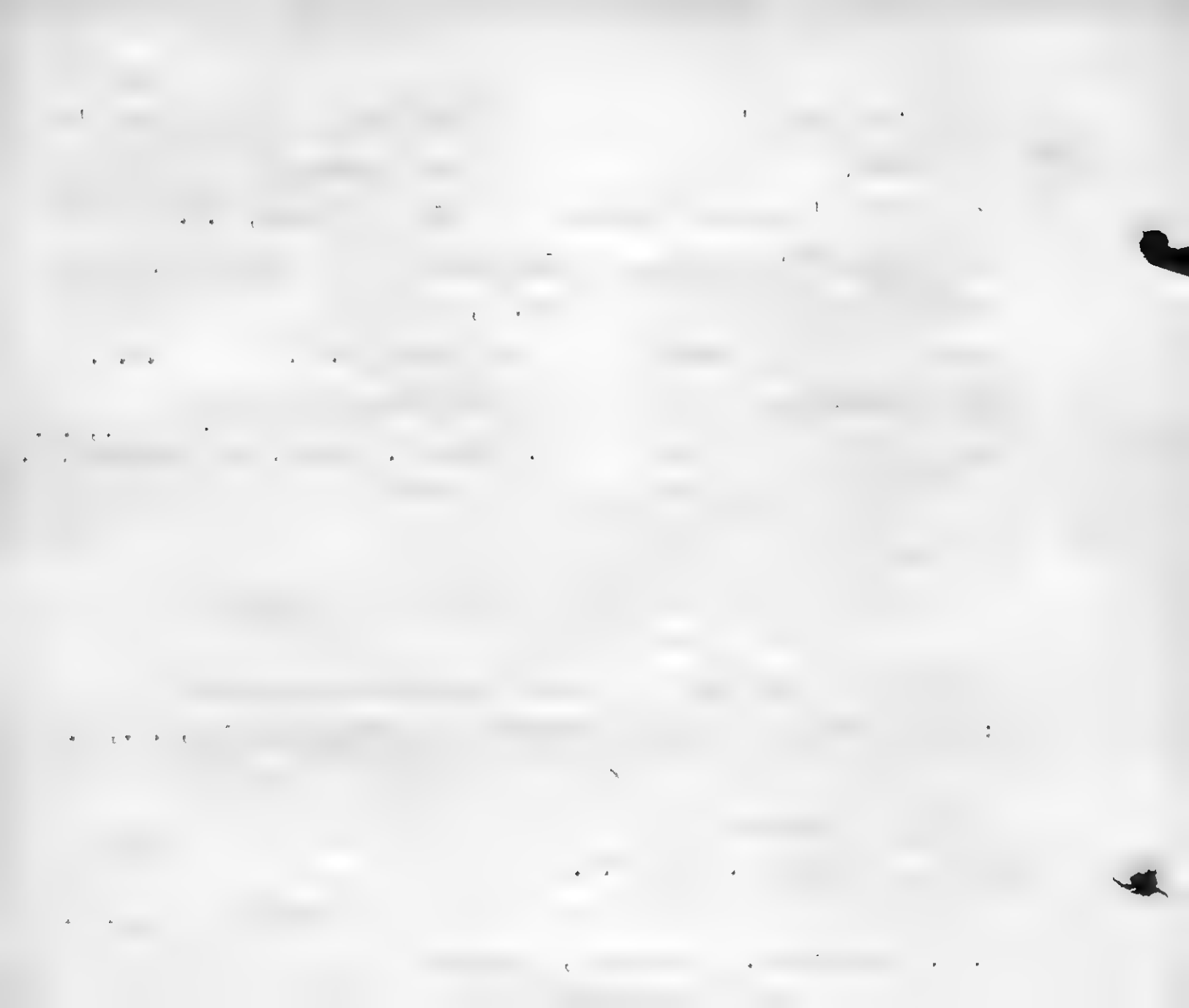
Arthur L. Knapp

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04879

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Seat Pleasant	
3. NAME OF DECEASED (Type or print) Doris Evelyn Blankenship		4. DATE OF DEATH April 5th, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 2, 1954		8. DATE OF BIRTH 8 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE State or foreign country Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Blankenship		14. MOTHER'S MAIDEN NAME Pauline Virginia Abbott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Pauline V. Abbott, Seat Pleasant, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONTUSIONS OF BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL PNEUMONIA	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE OF DEATH PRIMARY or CONTRIBUTING CAUSE OF DEATH	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Skating in the street when stuck by automobile		20c. TIME OF INJURY Month Day Year 5:15 p.m. 3/24 62	
20d. INJURY OCCURRED While at work Not While at work <input checked="" type="checkbox"/> Street		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) Carmondy Hills, P.O., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. BURIAL, CREMATION, or other disposition of remains (Specify) Burial	
22b. DATE THEREOF April 10, 1962		22c. NAME OF CEMETERY Mud Fork Cemetery	
22d. LOCATION (City, town, or country) (State) Mud Fork, Logan Cty. W. Va.		23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland	
24a. REC'D BY REGISTRAR APR 11 '62		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04881

04880

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beltsville Memorial Hosp</u>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>4708 Glediths Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. NAME OF DECEASED (Type or print) <u>John W</u> First Middle Last 6. DATE OF DEATH <u>April 9 1962</u> Month Day Year 7. SEX <u>male</u> 8. COLOR OR RACE <u>white</u> 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10. DATE OF BIRTH <u>10 31 - '80</u> 11. AGE (In years last birthday) <u>81</u> yrs. 12. IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> 13. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Edward Ronald</u> 14. MOTHER'S MAIDEN NAME <u>Phoebe</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>Spanish - Amr</u> 17. INFORMANT <u>Hospital Record</u> Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>Badger's disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. p.m. <u></u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4-9</u> , 19 <u>62</u> , to <u>4-9</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>62</u> , and that death occurred at <u>4:15</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>D.R. Purdie</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u></u> 22d. ADDRESS <u></u> 22b. DATE SIGNED <u></u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/13/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) <u>Arlington, Va.</u> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u> 25a. REC'D BY REGISTRAR <u>APR 12 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					



FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04882

04881

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) D.O.A.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 74 Beltsville
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen.
e. STREET ADDRESS 12424 Old Gun Power Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS 12424 Old Gun Power Rd.

3. NAME OF DECEASED (Type or print) Regina Marie Bowen
4. DATE OF DEATH April 22 1962
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Feb. 10, 1962
9. AGE (In years last birthday) 2 10. UNDER 1 YEAR ☐ 11. UNDER 24 HRS. ☐
12. CITIZEN OF WHAT COUNTRY? USA

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.
12. CITIZEN OF WHAT COUNTRY? yes USA

13. FATHER'S NAME Charles L. Bowen
14. MOTHER'S MAIDEN NAME Ester Marie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. None 17. INFORMANT Charles L. Bowen - Same as #2
(Yes, no or unknown) (If yes give war dates of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral
DUE TO 491X
Conditions if any, which gave rise to immediate cause (b) 491X
(a), stating the underlying cause last, (c) 491X
DUE TO 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 hours
INTERVAL BETWEEN ONSET AND DEATH 24 hours

19. WAS AUTOPSY PERFORMED? ☒ YES ☐ NO

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐
Hour a.m. 19 at work ☐ at work ☐
p.m. 19

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASS STANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Paul C. Van Natta M.D. acting
EXAMINER'S NAME (Type) Paul C. Van Natta
DATE SIGNED 4/22/62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4/24/62
22c. NAME OF CEMETERY OR CREMATORY Derwood Cemetery
22d. LOCATION (City, town, or country) (State) Derwood, Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland
ADDRESS Bethesda, Maryland

24a. REC'D BY REGISTRAR APR 26 1962
24b. REGISTRAR'S SIGNATURE Charles L. Bowen

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if day is necessary, and 3 to the funeral director. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIME
SM 1/62

2-152223



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04883

CERTIFICATE OF DEATH

04882

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berwyn, Hgts, Md.</u> d. STREET ADDRESS <u>9112 Baltimore Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MECK ELIZA Boyle</u>		4. DATE OF DEATH <u>April 28 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUG 16, 1882</u> <u>79</u> yrs.		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY FITZHUGH</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>Neep. Record</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>286.5</u> DUE TO (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Malnutrition and dehydration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>? 1 month</u> <u>? 1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>						20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>4-28</u> <u>1962</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ronald E Krum</u> 22b. DATE SIGNED <u>4-28-62</u> 22c. PHYSICIAN'S NAME (Type) <u>RONALD E KRUM</u>				22d. ADDRESS <u>LELAND MEM HOSPITAL, RIVERDALE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-1-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> 23d. LOCATION (City, town or county) <u>Bladensburg, Maryland.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.; Riverdale, Md.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

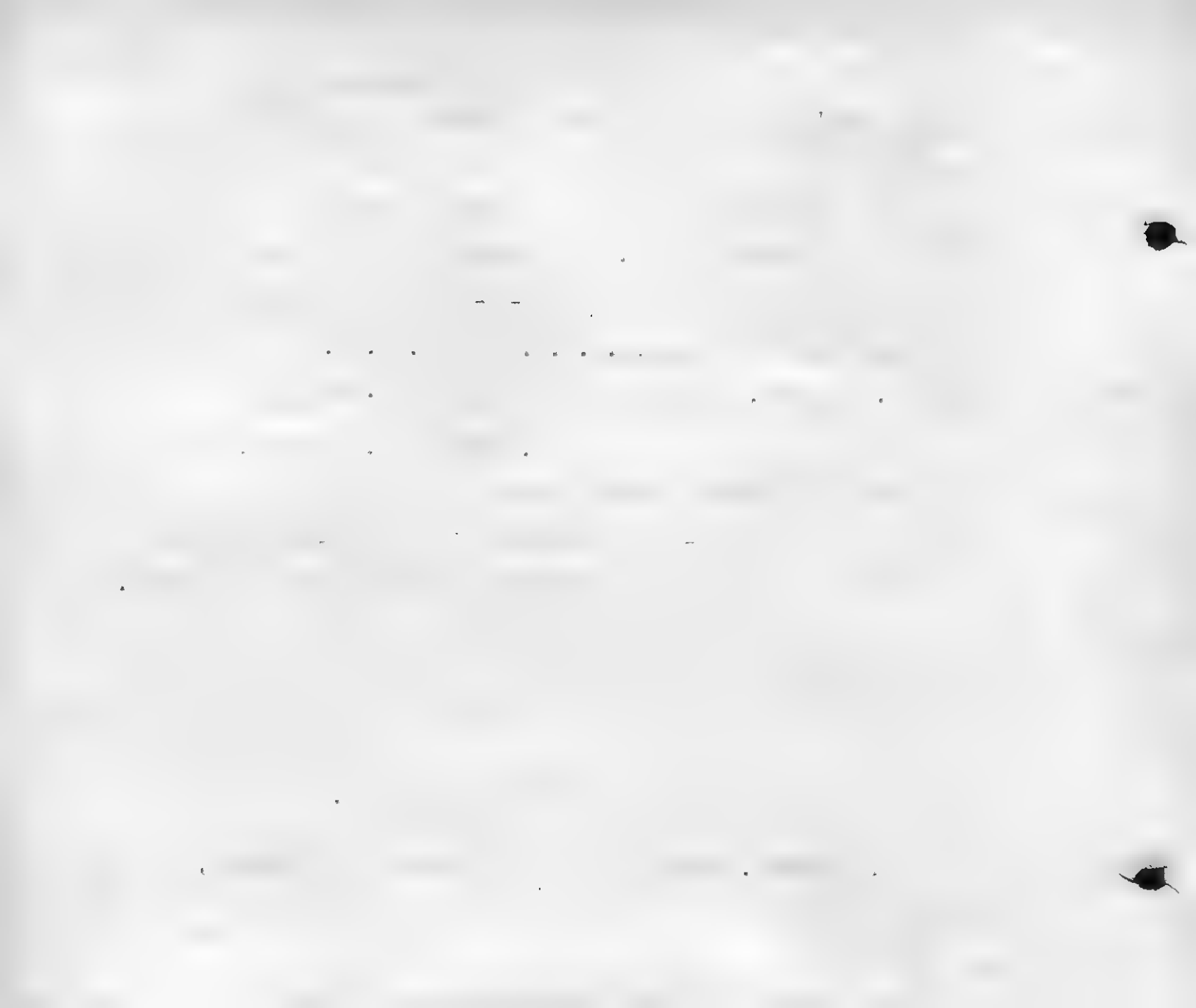


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04884
04883

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if not put on; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5010 Luguna Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles A. Bradley		4. DATE OF DEATH Month April Day 2 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-11
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Director of Personnel, N.L.R.B.		10b. KIND OF BUSINESS OR INDUSTRY Wash. D. C.	
11. BIRTHPLACE (County & State, or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? Wash. D. C.	
13. FATHER'S NAME George E. Bradley,		14. MOTHER'S MAIDEN NAME Katherine B. Bradley,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 000-00-0000	
17. INFORMANT Mrs. Dorothy A. Bradley, wife,		Address 1 day	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5 8/10 IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Porto-Caval Anastomosis (3 days post-operative) DUE TO (c) Cirrhosis of the Liver with bleeding esophageal varices known			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No	
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No		20f. (City or town) (County) (State) No	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1961 to 4-2-62 19 62 , that (I) (we) last saw the deceased alive on 4-2-62 19 62 , and that death occurred at 11:50 from the causes and on the date stated above.			
22a. SIGNATURE William C. Weintraub		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. William C. Weintraub		22d. ADDRESS 9 E. Parkway Rd., Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/5/62	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEM.		23d. LOCATION (City, town or county) (State) ARLINGTON	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Haulen		25a. REC'D BY REGISTRAR APR 9 '62	
25b. ADDRESS 4748 Wisc Ave.		25c. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04885

04884

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 10 U Southway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pauline C. Brandenburg		4. DATE OF DEATH Month Day Year April 30 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-25 9. AGE (In years last birthday) 36 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Iowa 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James C. Monahan		14. MOTHER'S MAIDEN NAME Clara Baxter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Nevin G. Brandenburg same as #2 (Husband) Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 518 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) Pulmonary Edema Empyema & Encephalopathy - etiology undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 3 months 3 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 11:15 A.M.
21. I certify that (I) (this hospital) attended the deceased from Jan 3 1962 to April 30 1962, that (I) (we) last saw the deceased alive on April 30 1962, and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. William C. Weintraub M.D.		22b. DATE SIGNED April 30 1962	
22c. PHYSICIAN'S NAME (Type) Dr. William C. Weintraub		22d. ADDRESS 9 E Parkway Rd., Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/3/62	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town or county) (State) Frederick, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE MAY 4 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	





TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

04886

04897

Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach d. STREET ADDRESS General Del.	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Britt		4. DATE OF DEATH Month April Day 7 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 April 1962	
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 24 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY None	
12. BIRTHPLACE (County & State, or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Walter		15. MOTHER'S MAIDEN NAME Margaret	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 6-12-345678	
18. INFORMANT Mother		19. ADDRESS Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Bilateral Pulmonary Atelectasis Conditions, if any, which gave rise to immediate cause (b) 2. Congenital Heart Disease (a), stating the underlying cause last. (c) None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year April 7, 1962			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) (County) (State) North Beach Prince Georges Maryland			
21. I certify that (I) (this hospital) attended the deceased from 6 April 1962 to 7 April 1962 , that (I) (we) last saw the deceased alive on 6 April 1962 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. R. Sasscer M.D.			
22b. DATE SIGNED 7 April 1962			
22c. PHYSICIAN'S NAME (Type) Dr. R. Sasscer, M.D.			
22d. ADDRESS Upper Marlboro., Md			
23a. BURIAL, CREMATION, REMOVAL, Specify Cremation			
23b. DATE THEREOF 4-13-62			
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital			
23d. LOCATION (City, town or county) (State) Cheverly, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Pann, Jr., Administrator ADDRESS Upper Marlboro., Md			
25a. REC'D BY REGISTRAR APR 23 '62			
25b. REGISTRAR'S SIGNATURE John S. House			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

<div>1</div> <div>04889</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>04888</div> <div>Item 23 Film 0312 5/1/62</div>											
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE District of Columbia							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN b. 4 hrs				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF Hospital Andrews				d. STREET ADDRESS 2243 Chester St SE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY BOY				4. DATE OF DEATH Month April Day 25 Year 1962							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 April 62		9. AGE (In years last birthday) yrs. Months Days 4		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Brown				14. MOTHER'S MAIDEN NAME Mabel R. Tabb							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO None				17. INFORMANT Hospital Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 775x DUE TO Immaturity (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 hrs 4 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that (this hospital) attended the deceased from 25 April, 1962 to 25 April, 1962 that (s) (we) last saw the deceased alive on 25 April, 1962 and that death occurred at 2:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Nicholas P. Haritos M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 25 April 62			
22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS, Capt USAF MC						22d. ADDRESS USAF HOSP, ANDREWS AIR FORCE BASE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated				23b. DATE THEREOF April 26, 1962		23c. NAME OF CEMETERY OR CREMATORY DC Morgue		23d. LOCATION (City, town or county) (State)			
24 FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR DATE APR 27 '62		25b. REGISTRAR'S SIGNATURE	

2-06



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04890

04889

1. PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institutions Residence before admission) a. STATE Md. b. COUNTY PG c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill Road, Landover, Md. d. STREET ADDRESS Hill Road, Landover, Md. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard F Brown 4. DATE OF DEATH 5 1962		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-1-73 9. AGE (In years last birthday) 88 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 11. BIRTHPLACE (County & State, or foreign country) Landover Maryland 12. CITIZEN OF WHAT COUNTRY? Landover Maryland	
13. FATHER'S NAME Richard Brown 14. MOTHER'S MAIDEN NAME Mildred J. Grabitt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 18 yrs 17. INFORMANT Mrs Bessie Brown-- same as above.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Cerebral vascular accident DUE TO 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 2. Cerebral arteriosclerosis DUE TO 3. Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 18 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 4-5 19 62 to 7-5 19 62 , that (I) (we) last saw the deceased alive on 4-5 19 62 and that death occurred at 9:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Peter Duus 22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22b. DATE SIGNED P.M. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-8-62		23c. NAME OF CEMETERY OR CREMATORY Addison Chapel 23d. LOCATION (City, town or county) (State) Seat Pleasant, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees 24b. ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR APR 11 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04891
04890

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myattsville c. LENGTH OF STAY IN b. 4 1/2 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor, 4922 La Salle Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington 9, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1629 Columbia Rd., N.W. d. STREET ADDRESS 1629 Columbia Rd., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Kent Brown 4. DATE OF DEATH April 20 1962		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 4, 1888 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Lincoln, Nebraska 11. BIRTHPLACE County & State or foreign country U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Miles Bainbridge King 14. MOTHER'S MAIDEN NAME Clara Kent		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Clyde G. Brown (Husband) 1629 Col. Rd., N.W. Address Wash 9 D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 9 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		21. I certify that (I) (the funeral) attended the deceased from Nov. 13 to April 20, 1962 that (I) (we) last saw the deceased alive on April 16, 1962 , and that death occurred at 12:30 AM , from the causes and on the date stated above.	
22a. SIGNATURE George Dewey 22c. PHYSICIAN'S NAME (Type) George Dewey, M.D.		22b. DATE SIGNED 4/20/62 22d. ADDRESS 1629 Columbia Rd., N.W., Washington 9, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 23b. DATE THEREOF 4-21-62 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY 23d. LOCATION (City, town or county) (State) SUITLAND Md.		24. FUNERAL DIRECTOR'S SIGNATURE JOSEPH GAWLER'S SONS, INC. 25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE J. S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04892

CERTIFICATE OF DEATH

04891

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b Em. Room d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights d. STREET ADDRESS 7800 District Hghts., Pkwy. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna M. Bruce		4. DATE OF DEATH April 10 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-12-27
9. AGE (in years last birthday) 34 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operate		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME August Heimbuch		14. MOTHER'S MAIDEN NAME Kathryn Confort	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 214-24-8907	
17. INFORMANT Kathryn Heimbuch		18. ADDRESS 8139 Old Pike Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Complete Heart Block Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1961 to April 8, 1962 that (I) (we) last saw the deceased alive on April 8, 1962 , and that death occurred at 11:55 from the causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 4/11/62	
22c. PHYSICIAN'S NAME (Type) Dr. M. M. Herzberg		22d. ADDRESS 7016 Greigg Street, Seat Pleasant, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-62	
23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles Riedel ADDRESS 1211 Chesapeake Ave.		25a. REC'D BY REGISTRAR DATE APR 17 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04893

04892

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u> c. LENGTH OF STAY IN IT <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holand Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4018 Hamilton St</u>	
3. NAME OF DECEASED (Type or print) <u>August Eugene Burgess</u> First Middle Last		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-18-88</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman E. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Katherine E. Grimm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Hospital Record</u> Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>nephritis chronic glom.</u> (b) <u>592X</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1962</u> to <u>April 27, 1962</u> that (I) (we) last saw the deceased alive on <u>4-27-62</u> and that death occurred at <u>08:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard Hays</u> 22b. NAME (Type) <u>LEONARD HAYS</u>		22c. ADDRESS <u>Hyattsville, Md</u> 22d. LOCATION (City, town or county) <u>Hyattsville</u> (State) <u>Md</u>	
23a. BURIAL, CREMATION <u>Burial</u> 23b. DATE THEREOF <u>May 1, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City, town or county) <u>Colman Manor</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gussak's Sons</u> ADDRESS <u>Hyattsville, Md</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04894

04893

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hosp.</u>		d. STREET ADDRESS <u>D-1 Cypress Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Carl J Cain</u>		4. DATE OF DEATH <u>April 29 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/1889</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) Internal Rev. Ser.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Cain</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>359-07-2279</u>	
17. INFORMANT <u>Mrs. Loretta Cain, D-1, Cypress Drive, ZONE 20</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalomalacia (Whole Left Brain)</u>			
414 DUE TO (b) <u>Arteriosclerosis Heart Disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) <u>L/Ventricle Hypertrophy</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>62</u> to <u>4/29</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/29</u> , 19 <u>62</u> , and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Hei K. Lee</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>HEI K. LEE</u>		22d. ADDRESS <u>7732 ANNAPOLIS RD. LANHAM, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 4 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

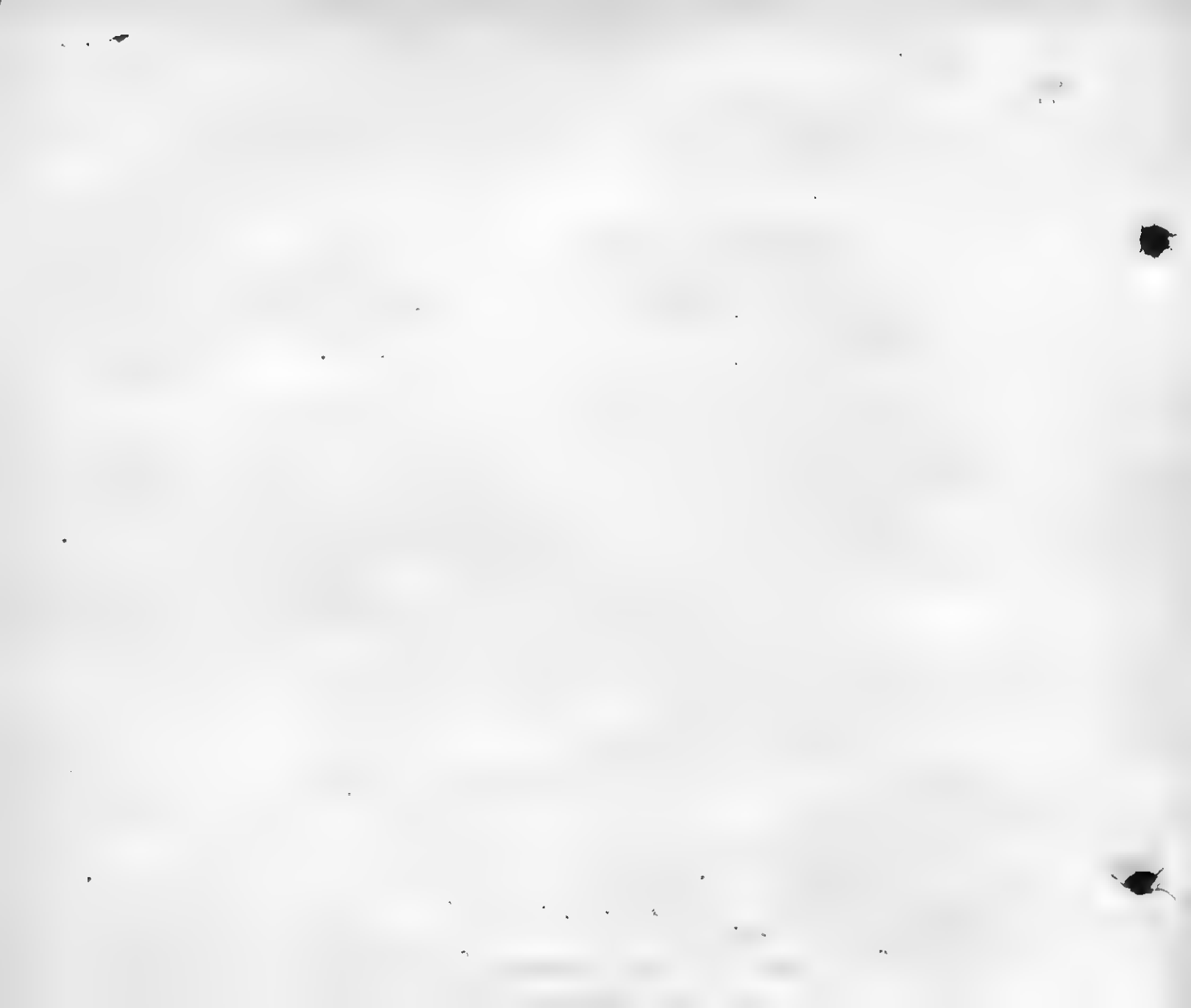
04895

CERTIFICATE OF DEATH

04894

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 2 years		d. STREET ADDRESS 1348 C Street, N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID		4. DATE OF DEATH April 28 1962	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH December 25, 1910		9. AGE (In years last birthday) 51 yrs.	
8. LEGALLY SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Helper	
11. BIRTHPLACE (County & State, or foreign country) Eastern High School Lawrence, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Caldwell		14. MOTHER'S MAIDEN NAME Carrie French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 577-14-5161	
17. INFORMANT Person		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Tuberculosis (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 yrs., 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/4 1960 to 4/28 1962, that (I) (we) last saw the deceased alive on 4/28 1962, and that death occurred at 12:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 5-2-62		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY HARMONY & NIEMI, Pk		23d. LOCATION (City, town or county) (State) 7601 SHERIFF RD, N.E. N.D.	
24. FUNERAL DIRECTOR'S SIGNATURE HOFFMAN FUN'L HOME		25a. REC'D BY REGISTRAR APR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



CERTIFICATE OF DEATH

04895

04895

Item 9 Film 0312 5/1/62 mh

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>	
c. LENGTH OF STAY IN <u>6 years</u>		d. STREET ADDRESS <u>2022 Lewisdale Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2022 Lewisdale Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lulu Gertrude Cowles</u>		4. DATE OF DEATH <u>April 23 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1884</u> <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Hartford, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hosea Potter</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Aldenhoten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Alden Cowles</u>		Address <u>2022 Lewisdale Dr. Hyattsville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of rectum</u> DUE TO (c) <u>1 1/2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Feb. 26</u> , 19 <u>62</u> to <u>April 23</u> , 19 <u>62</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>April 23</u> , 19 <u>62</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.		22b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d. ADDRESS <u>6480 N.H. Ave. Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, or (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 5, 1962</u>	
23c. NAME OF CEMETERY OR <u>Spring Grove</u>		23d. LOCATION (City, town or county) (State) <u>Hartford Connecticut</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

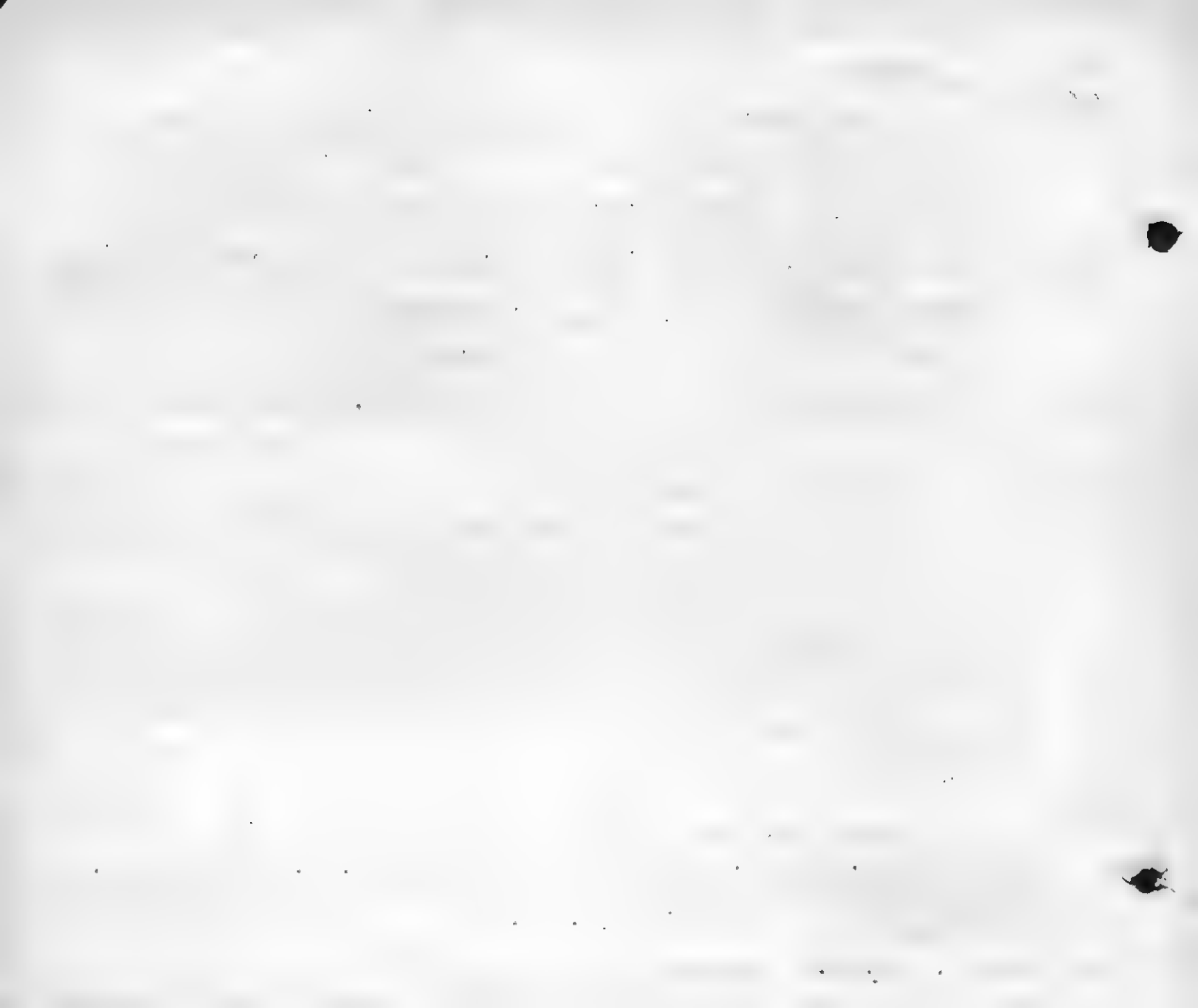
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04836

04836

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 12 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxen Hill d. STREET ADDRESS 5680 Spur Road	
3. NAME OF DECEASED (Type or print) Baby Girl Curtin 4. DATE OF DEATH April 26 1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 25 April 1962		9. AGE (In years last birthday) 6 yrs. 10. IF UNDER 1 YEAR Months 0 Days 0 11. IF UNDER 24 HRS. Hours 12 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Jackson Marshall		14. MOTHER'S MAIDEN NAME Glenda Jean Lobough Curtin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 5.404.11	
17. INFORMANT Mother		18. ADDRESS Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Atelectasis DUE TO Bilateral Adrenal Hemorrhage Conditions, if any, which gave rise to immediate cause (b) None (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Life	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year 4/25 1962 Hour a.m. 11:00 p.m. 00:00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville, Md.	
21. I certify that (I) (this hospital) attended the deceased from 4/25 1962 to 4/26 1962 that (I) (we) last saw the deceased alive on 4/26 1962 and that death occurred at 5:40 A.M. from the causes and on the date stated above.		22a. SIGNATURE Dr. Joseph J. McDonald M.D. 4/26/62	
22b. DATE SIGNED 4/26/62		22c. PHYSICIAN'S NAME TYPE Dr. Joseph J. McDonald	
22d. ADDRESS 7309 Riggs Rd., W. Hyattsville, Md.		22e. REC'D BY REGISTRAR May 8 '62	
22f. REGISTRAR'S SIGNATURE Arthur S. Kraus		22g. DATE May 8 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF May 5, 1962	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn		24b. ADDRESS Administrator	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C4898

04897

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 2 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 District Heights d. STREET ADDRESS 724 - 60th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl "A"		4. DATE OF DEATH Month April Day 25 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1962
9. AGE (In years last birthday) 12 yrs. 2 months 8 days 40 hours 40 min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Johnson Wheeler Kellibrew		14. MOTHER'S MAIDEN NAME Yvonne Deale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bilateral Pulmonary Atelectasis (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Life Life Life	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/23, 1962 to 4/25, 1962, that (I) (we) last saw the deceased alive on 4/25, 1962, and that death occurred at 5:28 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph J. McDonald		22b. DATE SIGNED 4/26/62	
22c. PHYSICIAN'S NAME (Type or print) Dr. Joseph J. McDonald		22d. ADDRESS 7309 Riggs Rd., W. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5 May 1962	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR MAY 8 '62	
25b. REGISTRAR'S SIGNATURE Carlton S. Hanna			

2-64-40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04899

04898

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>724-60th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl (B)</u>		4. DATE OF DEATH Last Month Day Year <u>Deale</u> <u>April</u> <u>30</u> <u>19 62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wheeler Kellibrew</u>		14. MOTHER'S MAIDEN NAME <u>Yvonne Deale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>62</u> , to <u>4/30</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>62</u> , and that death occurred <u>2:55M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Salvatore Battiatia</u> M.D.		22b. DATE SIGNED <u>P.M.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Salvatore Battiatia</u>		22d. ADDRESS <u>7309 Riggs Rd., Hyattsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-8-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prince Geo. Gen. Hospital</u>		23d. LOCATION (City, town or county) (State) <u>Cheverly, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Peen, Jr., Administrator</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

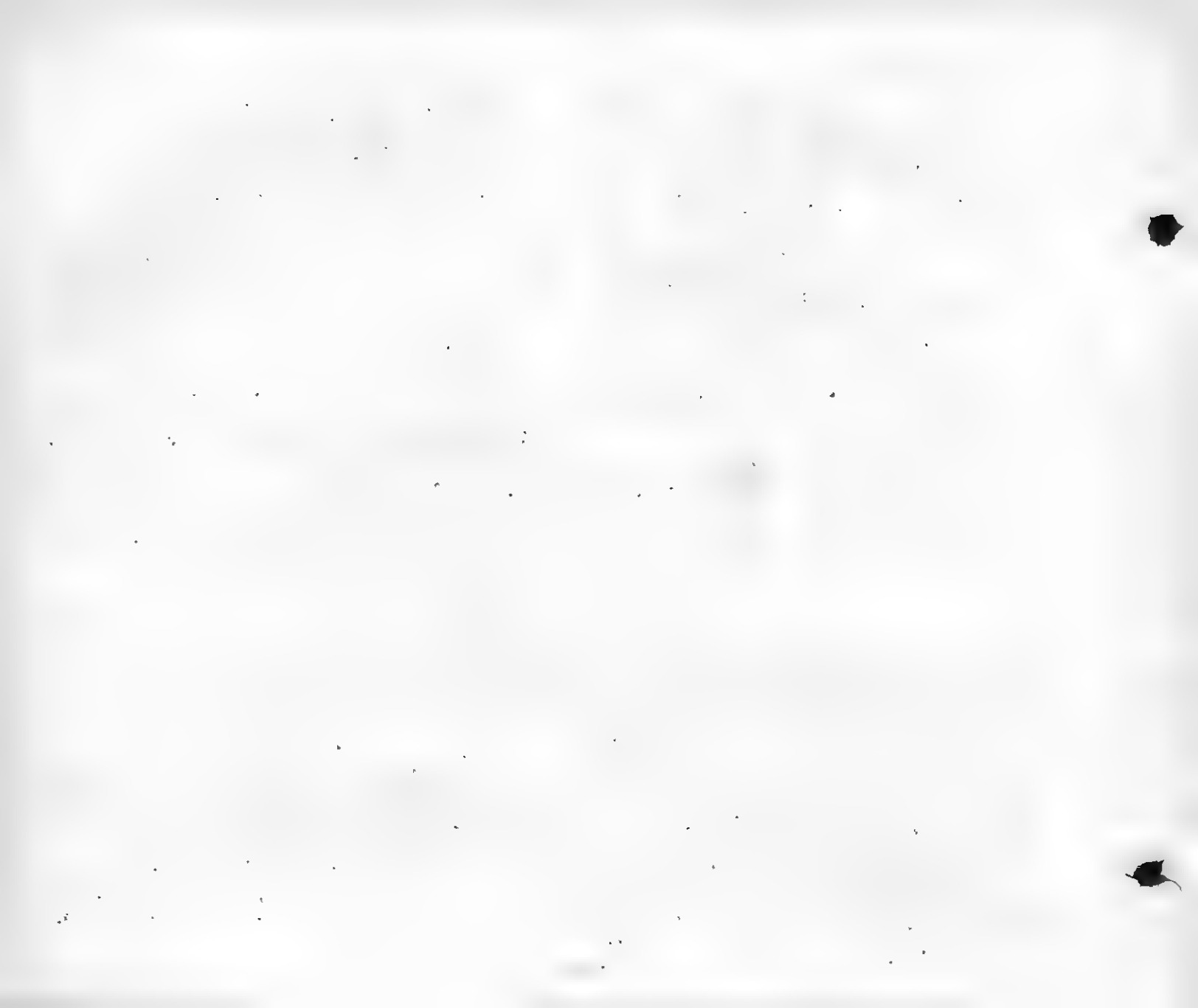
CERTIFICATE OF DEATH

Reg. Dist. No. 04899

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2418-Kirston street</u>		d. STREET ADDRESS <u>2418-Kirston street</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille J. Dennis</u>		4. DATE OF DEATH <u>4-24-1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1921</u>
9. AGE (In years last birthday) <u>40</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY W. ROSIE</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE BARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>John H. Dennis Jr. Husband</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>Leiomyosarcoma Inferior Vena Cava</u> DUE TO <u>1970</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1970</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1961</u> to <u>4-24-1962</u> that I last saw the deceased alive on <u>4-24-1962</u> and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jerome H. Epstein</u>		ADDRESS (Street, city or town, state) <u>2025 EYE ST, NW</u>	
PRINTED NAME (Type) <u>Jerome H. Epstein, MD</u>		DATE SIGNED <u>WASH 6, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/27/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>		ADDRESS <u>4th Rainier Md.</u>	
24a. DEC'D BY REGISTRAR <u>APR 30 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

04300

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Hills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3415 Stanford Street</u>		d. STREET ADDRESS <u>3415 Stanford Street</u>	
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>W</u> Last <u>DENT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1962</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1900</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>	11. BIRTHPLACE (State or foreign country) <u>DRAYDEN, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James W Dent</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Q Coulter</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO <u>217-36-8062</u>		17. INFORMANT <u>Beatrice Jones Dent</u> Address <u>3415 Stanford Street, University Hills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6-15-61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>6-15-61</u> , 19____, to <u>4-15</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-15-62</u> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Clum</u> M.D.		ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u> DATE SIGNED <u>4/16/62</u>	
PHYSICIAN'S NAME (Type) <u>JOHN P. CLUM, M.D.</u>		<u>6110 43rd Avenue, Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>		ADDRESS <u>Riverdale, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04902

04901

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN TB 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Roland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill d. STREET ADDRESS 6245 St. Barnabas Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herschel Eugene Dishner, Jr. 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 11, 1956 9. AGE (In years last birthday) 6 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH April 18 1962 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Country & State, or foreign country) Calisecenia U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herschel E. Dishner, Sr. 14. MOTHER'S MAIDEN NAME Marguerite E. Behrens 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) generalized peritonitis - toxic heart (c), stating the underlying cause last. suppurative gangrenous appendicitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(a)) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-10 1962 to 4-18 1962 that (I) (we) last saw the deceased alive on 4-18 1962 and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Howland F. Wilkinson 22c. PHYSICIAN'S NAME (Type) Howland F. Wilkinson 22b. ADDRESS 1400 Leensbury Fox Liverdale, Md.		22d. ADDRESS 22e. MED. DIRECTOR <input type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/> 22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-21-1962 23c. NAME OF CEMETERY OR CREMATORY Nat'l Memorial Park 23d. LOCATION (City, town or county) Falls Church, Va (State)		24. FUNERAL DIRECTOR'S SIGNATURE John A. Mittingly 25a. REC'D BY REGISTRAR APR 24 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04903

04902

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 340 Cree Drive		e. STREET ADDRESS 340 Cree Drive	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZA AUGUSTA DOWNS		4. DATE OF DEATH Month Day Year April 29, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1887
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Sween		14. MOTHER'S MAIDEN NAME Elizabeth Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Howard F. Downs		Address L.a., b., & above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary arteriosclerosis (c) general arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day unknown unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan 1, 1962 to April 29, 1962 that (I) (we) last saw the deceased alive on Jan 29, 1962 , and that death occurred at 7 PM , from the causes and on the date stated above.			
22a. SIGNATURE Henry S. Hadley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HENRY S. HADLEY MD		22d. ADDRESS 4601 Nichols Ave SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		25a. REC'D BY REGISTRAR DATE MAY 3 '62	
ADDRESS 317 Pa. Ave., SE Wash., D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04903

04904

1. PLACE OF DEATH
a. COUNTY Prince George's County
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly, Md.
c. LENGTH OF STAY IN MD
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5213 Baltimore Ave., Hyattsville, Md.
d. STREET ADDRESS 5213 Baltimore Ave., Hyattsville, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Wesley Middle W. WAYNE Last Downs, Sr.

4. DATE OF DEATH
Month 4 Day 17 Year 1962

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** 7-15-1901
9. AGE (In years last birthday) 60 yrs. **IF UNDER 1 YEAR** Months 0 Days 0 **IF UNDER 24 HRS.** Hours 0 Min 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist Dept of Army
10b. KIND OF BUSINESS OR INDUSTRY Dept of Army
11. BIRTHPLACE (Country & State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown **14. MOTHER'S MAIDEN NAME** Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO
16. SOCIAL SECURITY NO. Unknown **17. INFORMANT** Wesley Wayne Downs, Jr. Address Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO Arteriosclerosis Heart Disease
DUE TO Diabetes Melitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
260 **26c. TIME OF INJURY** Month, Day, Year 19 **26d. INJURY OCCURRED** White Not White at work at work
26e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 26f. City or town (County) (State)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. **20d. INJURY OCCURRED** White Not White at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) **20f. City or town** (County) (State)

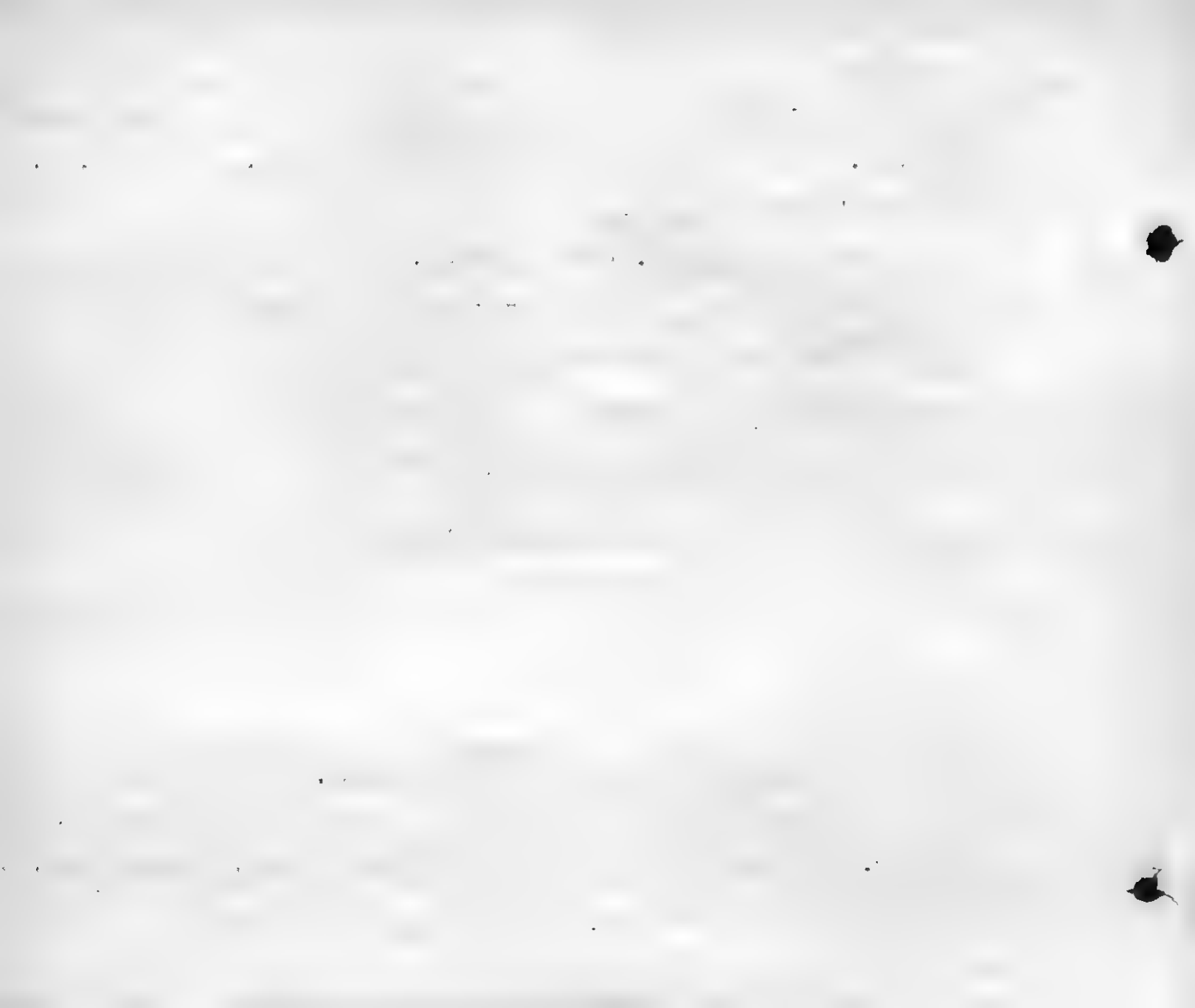
21. I certify that (I) (this hospital) attended the deceased from April 16, 1962, to April 17, 1962, that (I) (we) last saw the deceased alive on April 17, 1962, and that death occurred at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE Peter Duus **22b. DATE** April 18, 1962
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus **22d. ADDRESS** 6124 Central Avenue, Capitol Heights, Md.
22e. REC'D BY REGISTRAR Wesley E. Evans **22f. REGISTRAR'S SIGNATURE** Wesley E. Evans

23a. BURIAL, CREMATION, REMOVAL, SPECIFIC Burial **23b. DATE THEREOF** 4-21-62 **23c. NAME OF CEMETERY OR CREMATORY** Washington National **23d. LOCATION** (City, town or county) (State) Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801 Cleveland Ave., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Deputy Medical Examiner. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04904

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b. 18 Hillcrest Heights
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5776 26th., Avenue
d. STREET ADDRESS
3. NAME OF DECEASED (Type or print) First Middle Last
Julius Klor Draheim
4. DATE OF DEATH Month Day Year
April 30, 1962
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH Sept. 30, 1916 45 yrs
9. AGE (in years last birthday) If UNDER 1 YEAR If UNDER 24 HRS.
Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Machinist 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. 11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Julius Draheim 14. MOTHER'S MAIDEN NAME Adeline Stallman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 11 16. SOCIAL SECURITY NO. 578-09-5679 17. INFORMANT Address Rose Draheim Same as #2
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion in Sudden
20. 1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular disease Unknown
(c) unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) natural causes
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Paul C. Van Natta CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D. ADDRESS (Street, city, town, or county) DATE SIGNED 4/30/62
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 3-62 22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. 22d. LOCATION (City, town, or country) (State) Arlington Va.
23. FUNERAL DIRECTOR Simmons Bros. Funeral Home ADDRESS 1641- Good Hope Rd SE DATE MAY 3 '62 REGISTRAR'S SIGNATURE Arthur S. Kline



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or delay is necessary, prior to execution of the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
SM 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04906

04905

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

Maryland

Prince George's

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

College Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

9719 53rd Avenue

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct. 11, 1917

9. AGE (In years last birthday)

44 yrs.

10. MONTHS

5th.

1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman Maintainer W.S.S.C.

10b. KIND OF BUSINESS OR INDUSTRY

Exter, New Hampshire

11. BIRTHPLACE (State or foreign country)

U.S.A.

13. FATHER'S NAME

Cleophus Dube

14. MOTHER'S MAIDEN NAME

Anna St. Jean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

Yes

WW II

003-01-9698

Mrs. Louise E. Dube, College Park, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/5/62

22a. BURIAL OR CREMATION DATE THEREOF

Burial

April 9, 1962

22c. NAME OF CEMETERY

Arlington National

22d. LOCATION (City, town, or country) (State)

Arlington, Virginia

23. FUNERAL DIRECTOR

W. W. CHAMBERS CO.

Riverdale, Md.

24a. REC'D BY REGISTRAR

DATE APR 11 '62

24b. REGISTRAR'S SIGNATURE

Charles E. Hume



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 21-23. Form 511-4-62 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04906 04906

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 29 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro
d. STREET ADDRESS P.O. Box 3303
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last Stephen HURLEY Duok
4. DATE OF DEATH April 3 19 62
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH SEPT 21 -1886
9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Painting House
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT William Henry Dale Address 3402 81st Ave Forestville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Fracture of right hip
4000 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs
20c. TIME OF INJURY Month, Day, Year 2-2 19 62
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Upper Marlboro, P.G., Maryland (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 4-3-62
ACTUAL SIGNATURE James I. Boyd M.D.
EXAMINER'S NAME (Type) Dr. James I. Boyd
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-7-1962
22c. NAME OF CEMETERY OR CREMATORY Washington National
22d. LOCATION (City, town, or country) Suitland, Maryland (State)
23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md.
ADDRESS
24a. REC'D BY REGISTRAR DATE APR 6 '62
24b. REGISTRAR'S SIGNATURE C. L. S. Flannery

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01908

04907

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Naylor d. STREET ADDRESS Naylor e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joann J. Duckett		4. DATE OF DEATH Month April Day 27 Year 1962		9. AGE (In years last birthday) 2 MONTHS 2 DAYS 1 HRS 1 MIN.			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John Francis Duckett		14. MOTHER'S MAIDEN NAME Matilda Gray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Matilda Gray - Brandywine, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute serious Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper Respiratory Infection DUE TO (c) none that I know				INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) natural causes					
20c. TIME OF INJURY Hour 19 e.m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul C. Van Natta		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Paul C. Van Natta		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/62		22c. NAME OF CEMETERY OR CREMATORY Holynist Church			
22d. LOCATION (City, town, or country) Brandywine, Md.		22e. (State)		22f. (County)			
23. FUNERAL DIRECTOR George J. Kelton		ADDRESS Appauas, Md.		24a. REC'D BY REGISTRAR WASH 2 '62			
24b. REGISTRAR'S SIGNATURE William S. Hines		24c. DATE MAY 2 '62					

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909

04908

1. PLACE OF DEATH
a. COUNTY

Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before coming to institution)
a. STATE
New Jersey
b. COUNTY
Camden

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Runnemeade
d. STREET ADDRESS
#19 11th Avenue

3. NAME OF
(Type or print)

DELLA AMANDA DUNGAN
5. SEX
Female
6. COLOR OR RACE
White
7. MARRIED ☒ NEVER MARRIED ☐ DIVORCED ☐

4. DATE OF DEATH
April 3 1962
8. DATE OF BIRTH
October 3, 1887 74
9. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Candymaker Candy

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Penns.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

David Ayers

14. MOTHER'S MAIDEN NAME

Amanda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)

No

16. SOCIAL SECURITY NO.

Wayne M. Milligan

9522 Washington Blvd.
Seabrook, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

Chronic occlusion

Coronary artery disease

Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Diabetes, obesity

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year
Hour a.m. p.m.
19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

4/3/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 7, 1962

22c. NAME OF CEMETERY OR CREMATORY

Hillside Cemetery

22d. LOCATION (City, town, or county) (State)

Roslyn Pa

23. FUNERAL DIRECTOR

F. Gasch's Sons Hyattsville, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE APR 6 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04910

04909

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution.)

a. STATE Maryland

b. COUNTY Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Friendly

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

8390 Old Fort Road

3. NAME OF DECEASED (Type or print)

Alice

Edelin

4. DATE OF DEATH

April 8th., 1962

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

September 10, 1908

9. AGE (In years, IF UNDER 1 YEAR, IF UNDER 24 HRS last birthday) Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE, State or foreign country

District of Columbia USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Mary Brawner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO

none

17. INFORMANT

723 Gresham Place NW Gertrude Blackman Washington, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.

Acute pulmonary ~~XXXXX~~ Edema

Congestive heart failure

Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

4/9/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/12/62

22c. NAME OF CEMETERY OR CREMATORY

St. Philip's Church

22d. LOCATION (City, town, or county)

Aguasco Pr. Md.

23. FUNERAL DIRECTOR

George S. Nelson

ADDRESS

Aguasco, Md

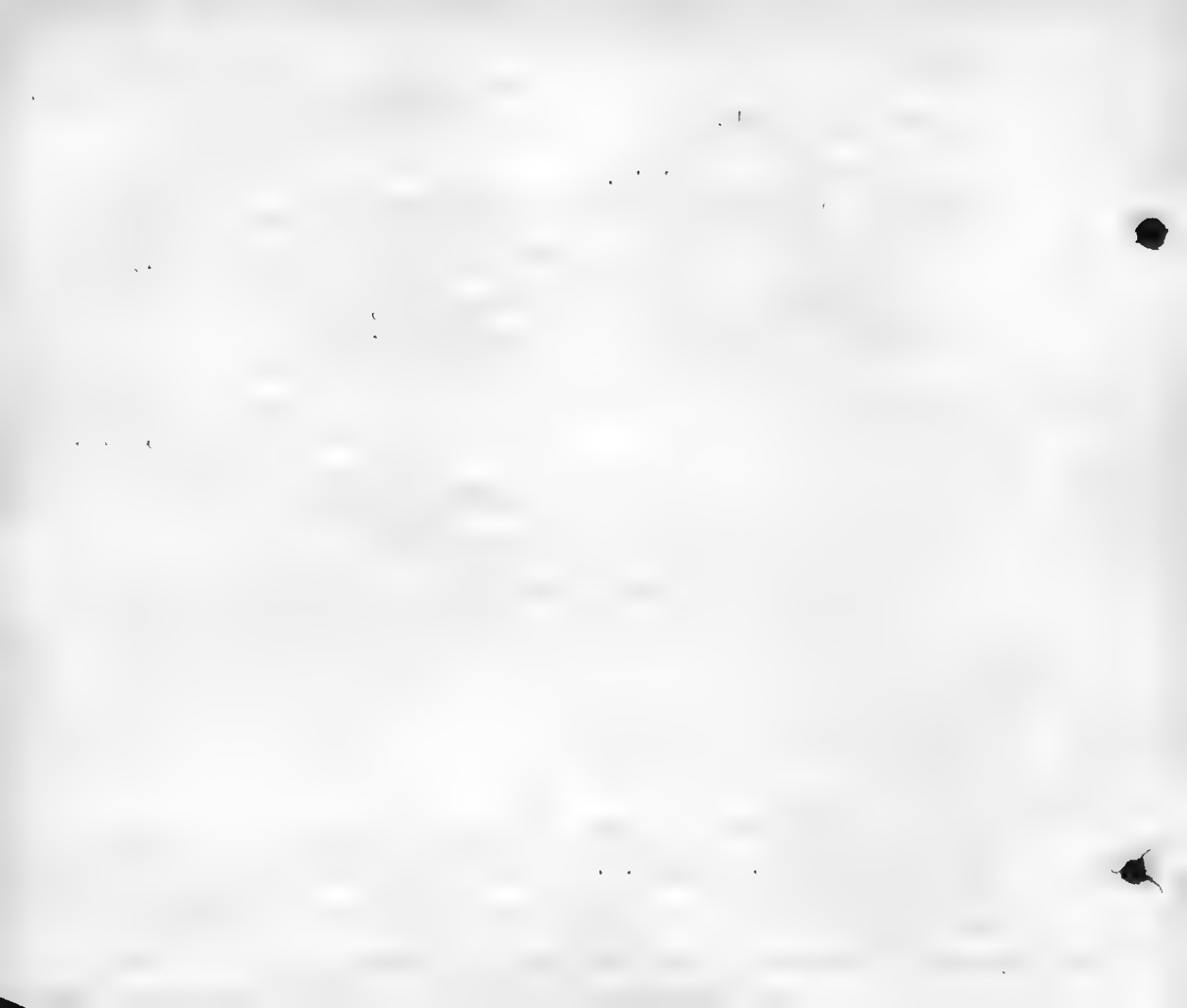
24a. REC'D BY REGISTRAR

DATE 4/9/62

24b. REGISTRAR'S SIGNATURE

Arthur S. Krum

APR 16 '62

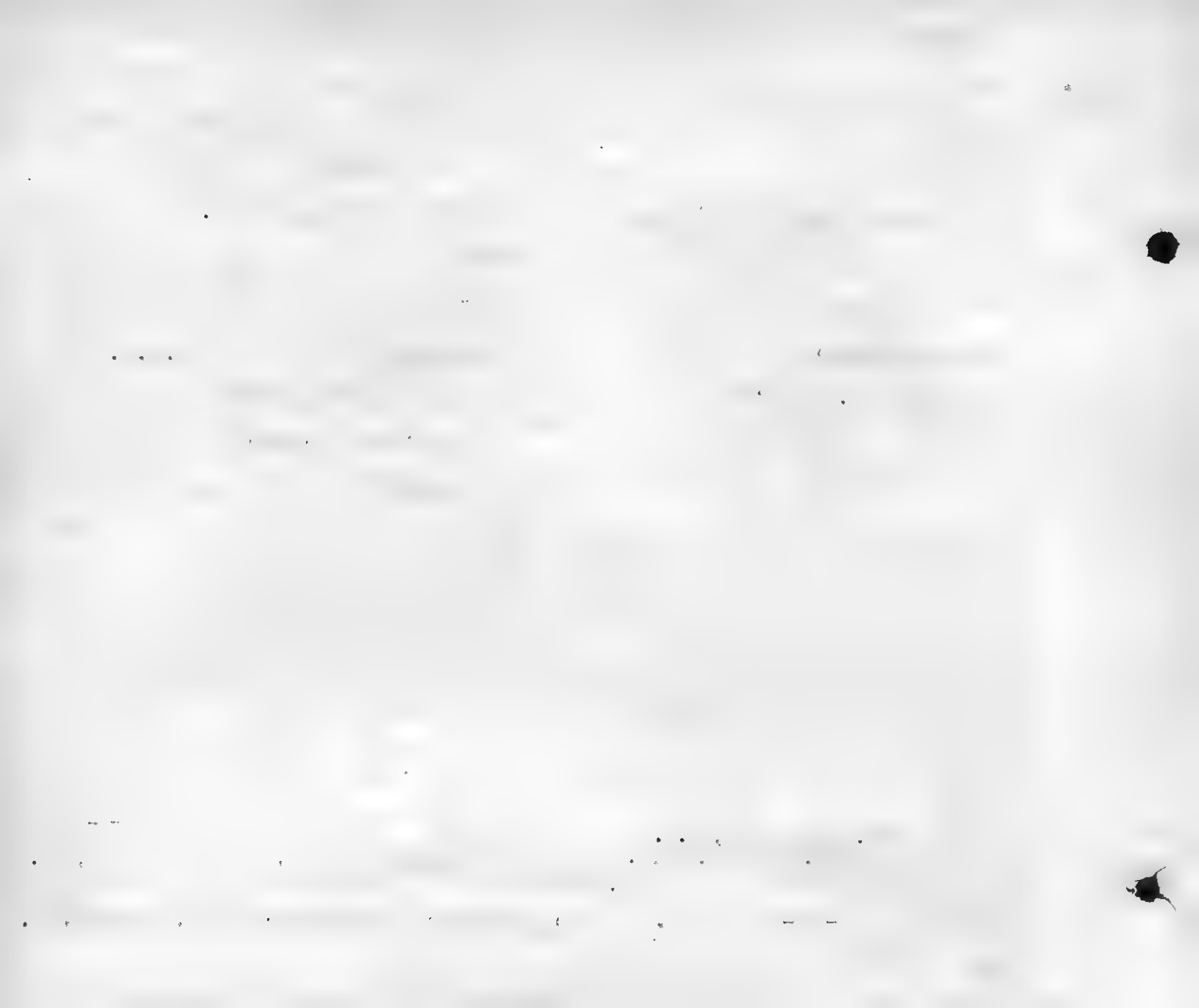


1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04911
04910
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admision) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6113 St. Margaret Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOAN Louise Baby Girl "B" Edwards		4. DATE OF DEATH April 8 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 April 1962	
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 4 Days 14	
11. IF UNDER 24 HRS. Hours 4 Min. 15		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant (none)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James L. Edwards	
14. MOTHER'S MAIDEN NAME Frances Louise Horman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 7-11-111111		17. INFORMANT Hospital Records	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular - Respiratory Insufficiency DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (b) 4 days (c) 4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Seat Pleasant		20g. (County) Prince Georges		20h. (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 4-4-62 to 4-8-62 , that (I) (we) last saw the deceased alive on 4-7-62 and that death occurred at 7:00AM from the causes and on the date stated above.					
22a. SIGNATURE Dr. Peter Duus, M.D.		22b. DATE SIGNED 4-8-62		22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus, M.D.	
22d. ADDRESS 6124 Central Ave., Capitol Heights, Md.		22e. (City or town) Capitol Heights		22f. (County) Prince Georges	
22g. (State) MD		22h. (Zip) 20743		22i. (Phone) 382-1474	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City, town or county) Prince Georges		23e. (State) MD		23f. (Zip) 20743	
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. ADDRESS 3821-14th St. N.W.		24b. (City or town) Washington, D.C.	
24c. (State) D.C.		24d. (Zip) 20004		24e. (Phone) 382-1474	
25a. REC'D BY REGISTRAR APR 11 '62		25b. REGISTRAR'S SIGNATURE L. H. Haines		25c. (City or town) Baltimore	
25d. (County) Prince Georges		25e. (State) MD		25f. (Zip) 21201	



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO A FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04912
CERTIFICATE OF DEATH
04911

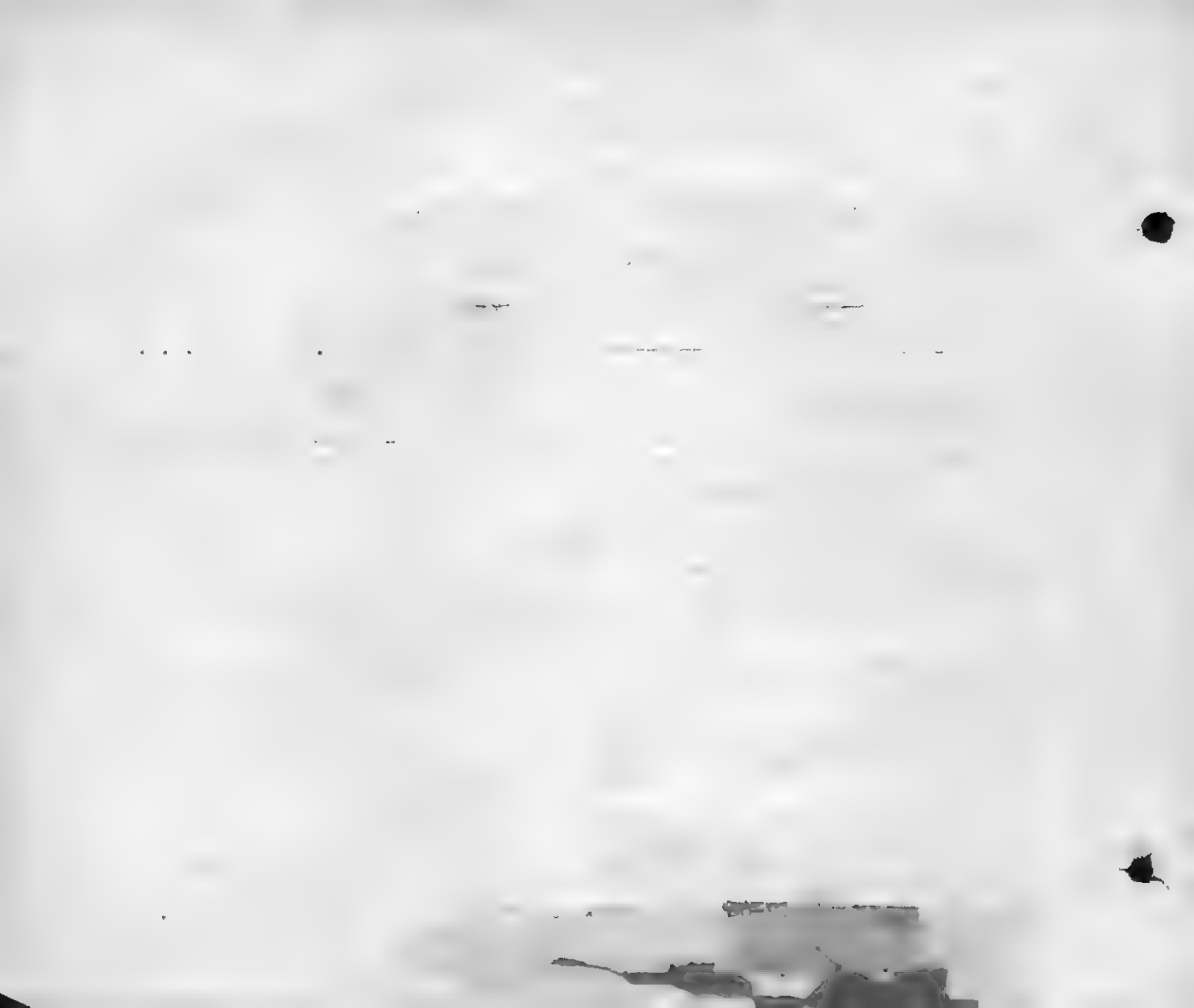
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cottage City			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia T & Fell		d. STREET ADDRESS 3708 37th Ave.			
5. SEX Female		6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 Oct. 1889			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U S Treasury		11. BIRTHPLACE (County & State, or foreign country) Washington D C			
13. FATHER'S NAME James Dalrymple		14. MOTHER'S MAIDEN NAME Priscella Torbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Hospital records			
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420 a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) chronic congestive heart failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) healed rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 30 days 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1956, to Apr 29, 1962, that (I) (we) last saw the deceased alive on Apr 28, 1962, and that death occurred at 6:15 AM from the causes and on the date stated above.					
22a. SIGNATURE Till Bergemann M.D.		22b. DATE SIGNED 4/29/62			
22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann, M.D.		22d. ADDRESS 53 D Crescent Rosa Greenbell M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962			
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
ADDRESS Hyattsville, Md.		DATE MAY 1 1962			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04912

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellsville	
c. LENGTH OF STAY IN IS 5 days		d. STREET ADDRESS Rt. 1 Box 68	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shirley Mae Harley	First M d d l e Last	4. DATE OF DEATH April 24 19 62	Month Day Year
5. SEX Female	6. COLOR OR RACE Negro Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-56
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 6 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Prince George Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis Proctor	14. MOTHER'S MAIDEN NAME Elizabeth Harley	Address Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. *****	17. INFORMANT Elizabeth Ford - Rt. 1- Box 68 Mitchellville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tubercula Secondary Infections 716.0 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DU TO (b) Multiple and extensive Burns abt body DU TO (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Circle Caught fire while Burning a Water		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4/19 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Mitchellville (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul C. V. Natta		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PAUL C. V. NATTA		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27-62	
22c. NAME OF CEMETERY OR CREMATORY Holy Family Catholic		22d. LOCATION (City, town, or country) Mitchellsville- Md. (State)	
23. FUNERAL DIRECTOR Charles L. 111		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAY 2 '62 Arthur S. Kline	



04914

CERTIFICATE OF DEATH

Reg. Dist. No. 04913

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Hospital</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesedy MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges' Hosp</u>		d. STREET ADDRESS <u>5406- 62nd Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>GERALD</u> Middle <u>WINFRED</u> Last <u>FOSTER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/82</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>11</u> Min <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent Brick Yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ingoldsby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>177-01-7499</u>	
17. INFORMANT <u>Mrs Jean Boswell</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (b) <u>CARCINOMA of COLON</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>4-3-</u> 19 <u>62</u> that I last saw the deceased alive on <u>4-3-62</u> , 19 <u>62</u> , and that death occurred at <u>8:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Roth</u> M.D.		ADDRESS (Street, city or town, state) <u>5510 MADISON ST RIVERDALE</u> DATE SIGNED <u>4-3-62</u>	
PHYSICIAN'S NAME (Type) <u>Albert Roth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-7-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Kittanning Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Kittanning Pennia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co. Riverdale</u> ADDRESS <u>md</u>		24a. REC'D BY REGISTRAR <u>APR 6 1962</u> 24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and within any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04914

1 PLACE OF DEATH
a. COUNTY Prince Georges County MARYLAND
b. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Cheverly
c. LENGTH OF STAY IN b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address Prince Georges General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Lanham
d. STREET ADDRESS Box 363

3. NAME OF DECEASED (Type or print) ROBERT VERNON FOWLER
4. DATE OF DEATH April 30, 19 62
Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Nov. 22, 1959
9. AGE (in years last birthday) 2 yrs. 10. IF UNDER 24 HRS. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Child 14. MOTHER'S MAIDEN NAME Child Cheverly, Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Vernon M. Fowler, Lanham, Md.
Address Box 363

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rente Toxic Broncho Pneumonia
085.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Infection
(a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): none of note
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐ (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Paul C. Van Natta, M.D. DATE SIGNED May 1, 1962
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D. Address (Street, city, town, or county) Arlington, Virginia

22a. BURIAL OR CREMATION (Specify) Burial 22b. DATE THEREOF May 4, 1962 22c. NAME OF CEMETERY Arlington National Cemetery 22d. LOCATION (City, town, or country) Arlington, Virginia
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md. ADDRESS 24. REGISTRATION SIGNATURE May 3 '62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04916

CERTIFICATE OF DEATH

Items 10, 11, 12, 13 & 14 Film 3-13 5/17/62 mh

04915

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cedar Heights d. STREET ADDRESS 6230 Lee Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tracy First Middle Last 4. DATE OF DEATH April 27 Month Day Year 19 62		5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8-3-09 9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY South Carolina 11. BIRTH PLACE (County & State, or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Press Garrison 14. MOTHER'S MAIDEN NAME Georgia Mathais	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. No 17. INFORMANT Edmon Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) severe hypertension (a), stating the underlying cause last, (c) urtemia DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/22 to 4/27 , 19 62 that (I) (we) last saw the deceased alive on 4/27 , 19 62 , and that death occurred at 7:16 from the causes and on the date stated above.	
22a. SIGNATURE Dr. Caesar M. Madarang 22c. PHYSICIAN'S NAME (Type) Dr. Caesar M. Madarang 22d. ADDRESS Prince George's General Hospital, Md.		22b. DATE SIGNED 4/27 22e. SIGNATURE Arthur S. Hume	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 1, 1962 23c. NAME OF CEMETERY OR CREMATORY NATL HARMONY PARK 23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.		24. FUNERAL DIRECTOR'S SIGNATURE Carroll E. Hume ADDRESS 611 K St. N.W. 25a. REC'D BY REGISTRAR MAY 4 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04917

04916

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 15 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6609 Oliver Street b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Lorena GIBSON		4. DATE OF DEATH Month Day Year April 7, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 25, 1896
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 66	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		11b. KIND OF BUSINESS OR INDUSTRY Y.M.C.A.	
11c. BIRTHPLACE (County & State, or foreign country) Dinwiddie County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. of Am.	
13. FATHER'S NAME Samuel Johnson		14. MOTHER'S MAIDEN NAME Mary Lou Langford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 579-28-2704A	
17. INFORMANT Russel M. Carrell		18. ADDRESS 6609 Oliver St., Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic Heart Disease DUE TO Arteriosclerosis Generalized		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 10 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month Day Year 19--		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (the hospital) attended the deceased from October 11, 1961 to April 7, 1962 , that (I) (we) saw the deceased alive on March 27, 1962 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE Walcutt W. Gibson, M.D.		22b. DATE SIGNED April 7, 1962	
22c. PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.		22d. ADDRESS 4340 St. Barnabas Road, Washington 21, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE See Funeral Home 300 4th St N.E.		25a. REC'D BY REGISTRAR DATE APR 11 1962	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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04918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04917

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived if not usual residence before death)

a. STATE

b. COUNTY

Maryland

Prince George's

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

d. STREET ADDRESS

4013 Longfellow Street

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Sidney

Gottley

4. DATE OF DEATH

April

26,

19 62

5. SEX

Male

White

6. COLOR OR RACE

WIDOWED ☐

DIVORCED ☐

7. MARRIED ☒ NEVER MARRIED ☐

June 11, 1917

8. DATE OF BIRTH

44 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Metallurgist

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov't.

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Aaron Gottley

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes W.W. 11

16. SOCIAL SECURITY NO

17. INFORMANT Norval Eugene Jones, 209 Bradley Ave., Rockville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Coronary Vascular Heart Disease

DUE TO

Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

none that I know

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day Year

20d. INJURY OCCURRED
While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Paul C. Van Natta

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4/26/62

EXAMINER'S NAME (Type)

Paul C. Van Natta, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/28/1962

22c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery Prince Georges County, Md.

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

The S.H.Hines Co.-2901 14th St., N.W.
Washington 9, D.C.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

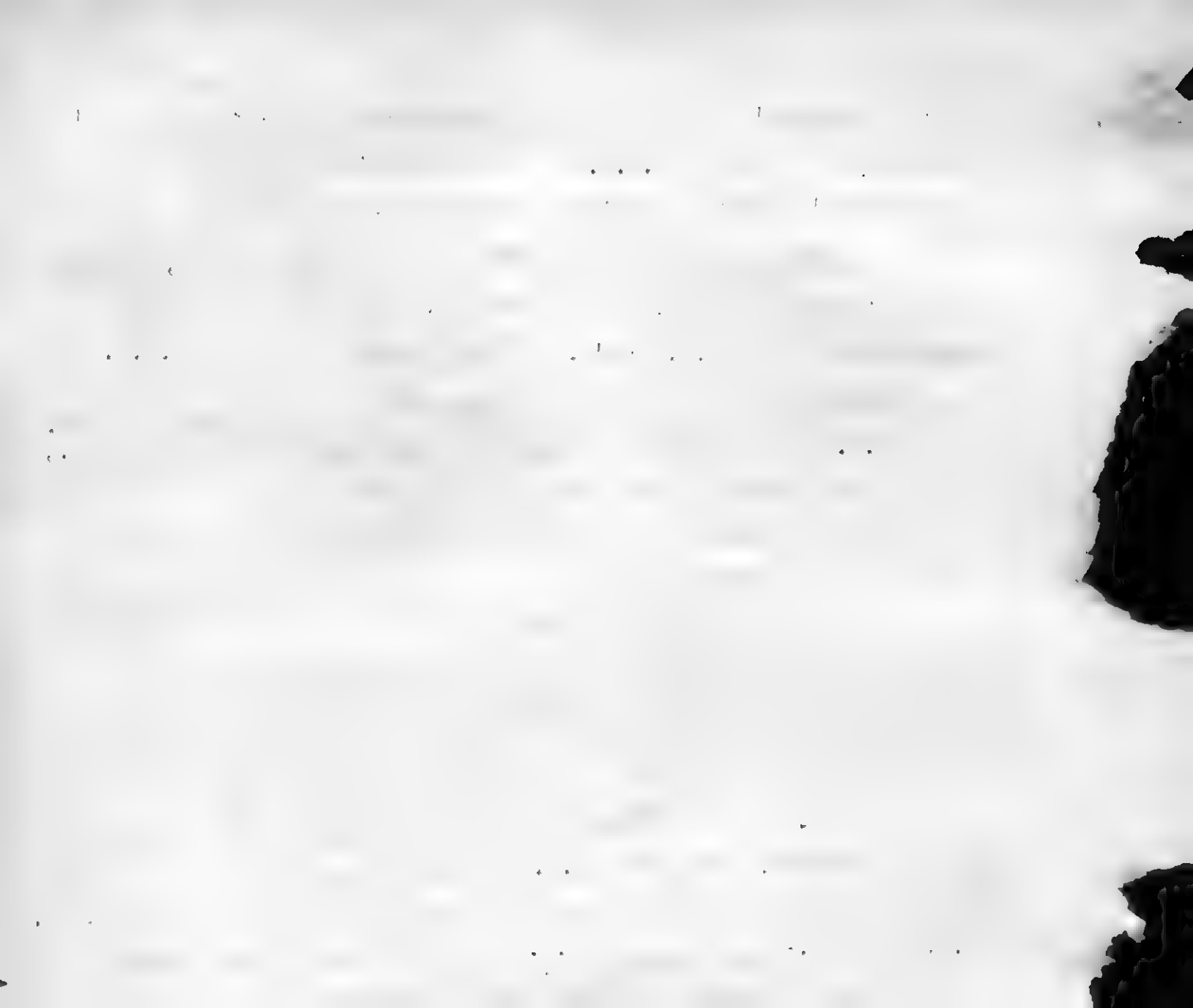
DATE APR 30 '62

Arthur L. Hines

any delay is necessary, the funeral director, pages 1, 2, and 3 to the funeral director, page 4 should be forwarded to the Chief Medical Examiner, and page 5 to the State Department of Health, or removal, and in any event within 72 hours after death.

M

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04919

04918

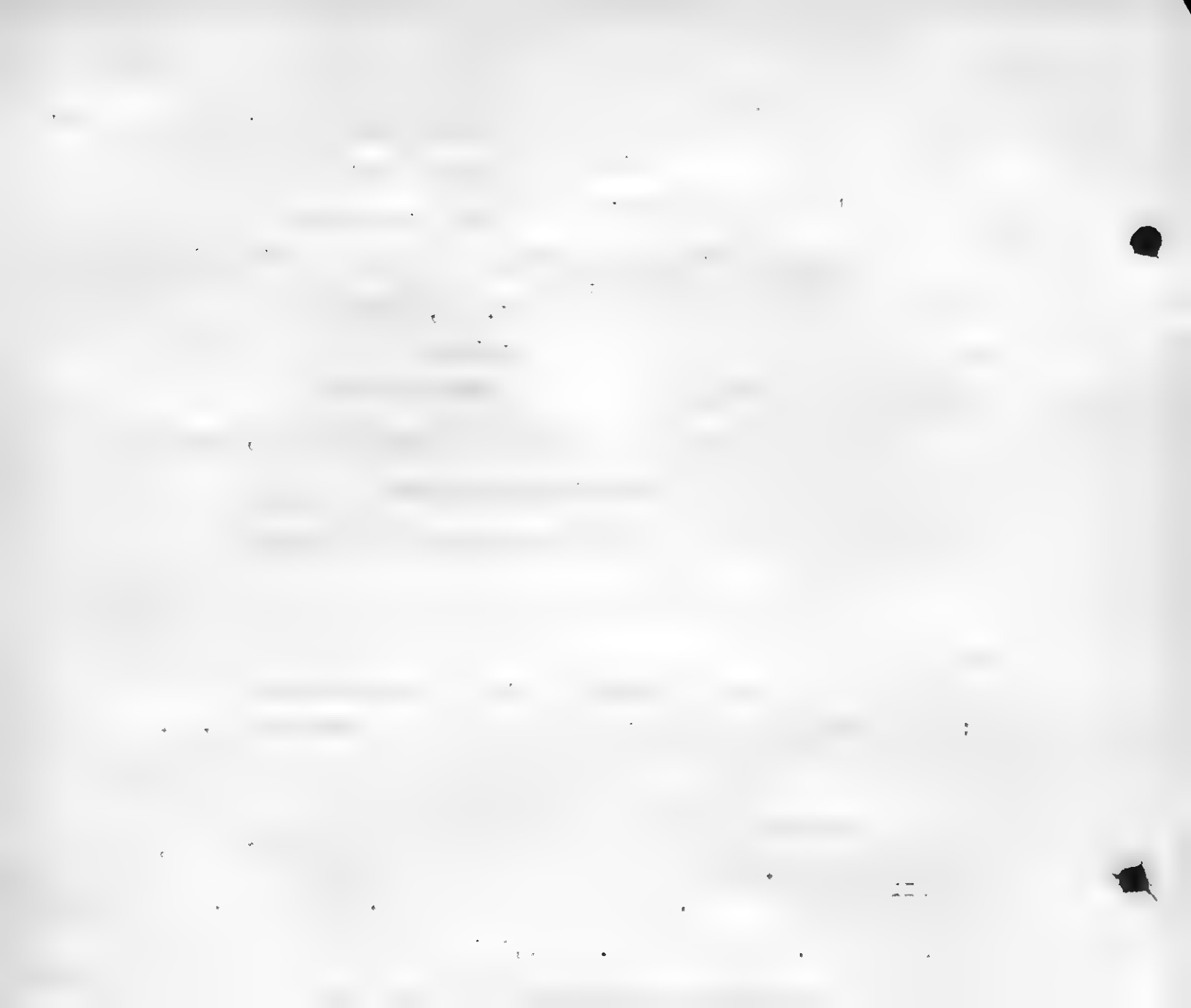
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6719 Fairwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosie First Middle Last Graham		4. DATE OF DEATH Month Day Year A pr. 10 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1878
9. AGE (in years last birthday) 83		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Harrison		14. MOTHER'S MAIDEN NAME Not Obtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Same as above	
17. INFORMANT Mrs. Mrs. Elsie Van Alstyne		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4-20-62 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II, of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/31 19 62 to 4/10 19 62 ; that (I) (we) last saw the deceased alive on 4/10 19 62 , and that death occurred at 6:30 P from the causes and on the date stated above.			
22a. SIGNATURE F. E. Mosser M.D.		22b. DATE SIGNED A pr. 10 1962	
22c. PHYSICIAN'S NAME (Type) F. E. Mosser		22d. ADDRESS 4410 24th Ave Souders	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 13 April 62	23c. NAME OF CEMETERY OR CREMATORY Methodist Protestant	23d. LOCATION (City, town or county) (State) Alexandria, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE W. Bandy Mountcastle		25a. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Charles L. Haines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



APR 18 '62

Arthur S. Krauss



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04921

04920

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 yrs - 10 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5008-36th Ave.</u>		d. STREET ADDRESS <u>5008-36th Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PERCY</u> Middle <u>LEE</u> Last <u>HALE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 16, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, D.C. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Hale</u>		14. MOTHER'S MAIDEN NAME <u>Josephine ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>E. Mrs. Ena Spencer</u>		Address <u>above</u> <u>Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SECONDS</u> <u>many</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>MAY 1, 1961</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>APRIL 2, 1962</u> and that death occurred at <u>10³⁰ PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Paul A. DeVore</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL A. DEVORE, M.D.</u>		22d. ADDRESS <u>3501 HAMILTON ST., HYATTSVILLE, MD.</u>	
22b. DATE <u>29 APR 1962</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colman Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier Md.</u>	
25a. REC'D BY REGISTRAR <u>3 62</u>		25b. REGISTRAR'S SIGNATURE <u>J. S. Finner</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
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6/15/62
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04922
07353
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rheverly c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchelville d. STREET ADDRESS Rt. #2, Box 41 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry O. Harley First Middle Last		4. DATE OF DEATH April 3 19 62 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-53 9. AGE (In years last birthday) 9 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wallace Harley		14. MOTHER'S MAIDEN NAME Helen Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Helen Turner, Mitchelville, Md.	
18. CAUSE OF DEATH (Enter only one cause per I for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) Hodgkins Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 670	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th s hospital) attended the deceased from 3-21 1962, to 4-3 1962, that (I) (we) last saw the deceased alive on 4-3 1962, and that death occurred at 11:55 AM, from the causes and on the date stated above			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED 4/3/62	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo		23d. LOCATION (City, town or county) (State) Mitchelville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson, Aquasco, Md.		25a. REC'D BY REGISTRAR DATE JUL 5 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04921

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Glendale
c. LENGTH OF STAY IN 1b 14 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marguerite Ave., Off Glendale Rd.
2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission on, a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Glendale
d. STREET ADDRESS off Marguerite Ave./Glendale Rd.
3. NAME OF DECEASED (Type or print) Douglas Nesbet Haselden
4. DATE OF DEATH April 24, 19 62
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct. 3, 1913 48 yrs.
9. AGE (In years last birthday) IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk 10b. KIND OF BUSINESS OR INDUSTRY Barry Industries So. Carolina
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stephen Osgood Haselden 14. MOTHER'S M.A.DEN NAME Rosa Lee Marlow
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 317-01-6882 17. INFORMANT Mary Eleanor Haselden Same as #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING
DUE TO
Conditions, if any, which gave rise to immediate cause (b) DUE TO
(a), stating the underlying cause last. (c)
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)
20c. TIME OF INJURY Month, Day, Year 12:20 a.m. 4/24 19 62
20d. INJURY OCCURRED White ☐ Not White ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence
20f. (City or town) Glendale (County) P.G. (State) Maryland.
21. I certify that I took charge of the remains described above, had an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☒
CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 4/24/62
ACTUAL SIGNATURE Paul C. Van Natta
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.
Address (Street, city, town, or county) Glendale, Md.
22a. BURIAL, CREMATION REMOVAL (Specify) Burial 22b. DATE THEREOF April 27, 1962 22c. NAME OF CEMETERY OR CREMATION St Georges Episcopal
22d. LOCATION (City, town, or country) (State) Glendale, Md.
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.
24a. REGISTRY APR 30 1962 24b. REGISTRAR'S SIGNATURE Arthur L. Harris

VR AISM
SM 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary. Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04924

04922

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

District Heights

c. LENGTH OF STAY IN 1b

D.C.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

District Heights Medical Center

3. NAME OF DECEASED
(Type or print)

Nevin

Robert

Haudenschild

5. SEX

Male

White

7. MARRIED ☐ NEVER MARRIED ☐

DIVORCED ☐

8. DATE OF BIRTH

June 5, 1910

9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min.

51 yrs.

April 16th, 1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ray Eugene Haudenschild

14. MOTHER'S MAIDEN NAME

Grace Sohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes

W.W. 11

276-03-8988

17. INFORMANT

Mary Kirkwood, 112 Druid Place

Address Parkland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

(b) DUE TO
(c) DUE TO

Cardiovascular renal disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour e.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/16/62

22a. BURIAL, CREMATION REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-19-1962 GREENLAWN CEMETERY Tiffin, OHIO

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

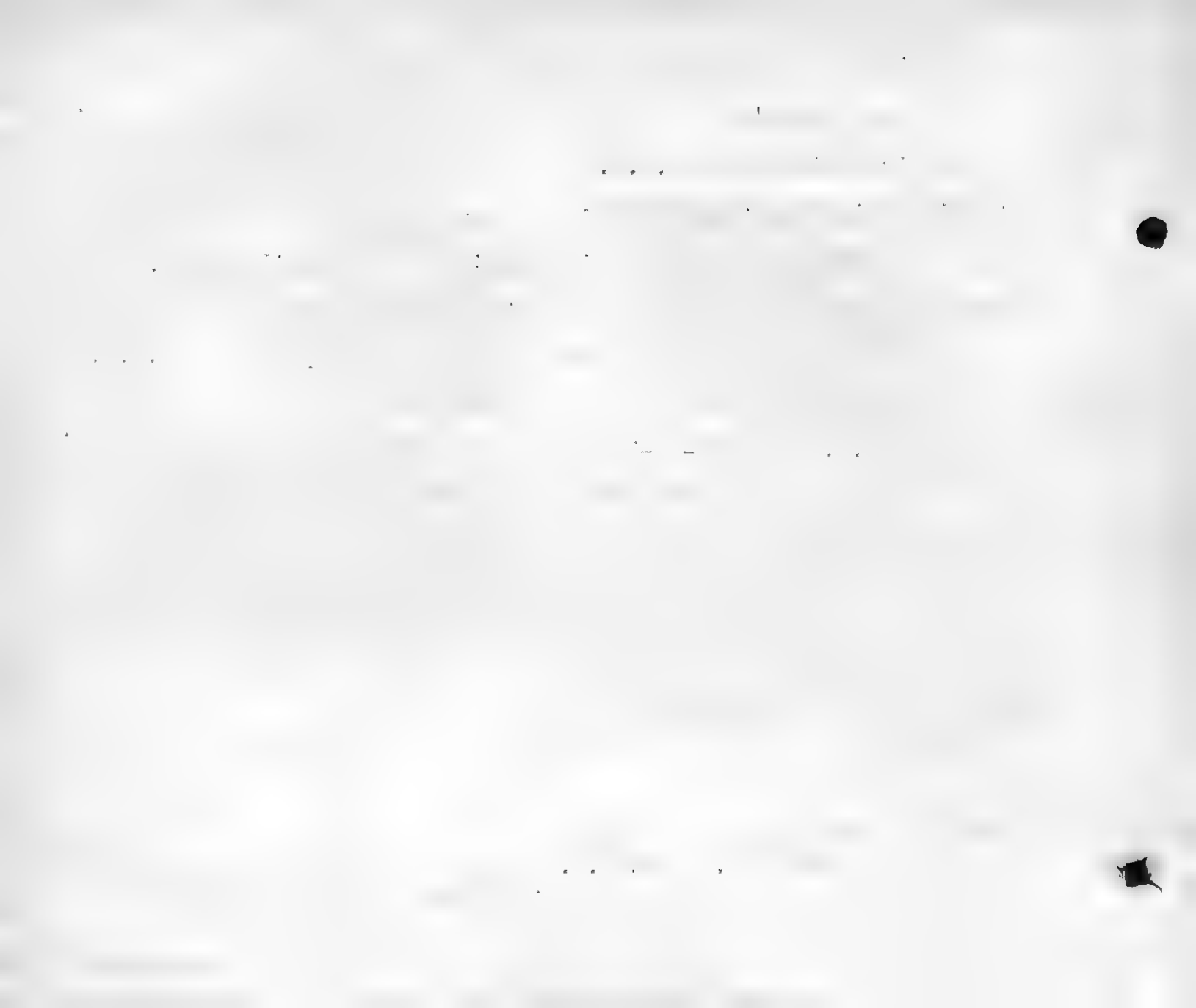
W.W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR

DATE APR 18 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Hume



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04923

Item 9 Film G311 4/17/62 mh

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) Glen Arden d. STREET ADDRESS 8627 Johnson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah First Middle Last Hawkins		4. DATE OF DEATH Month Day Year April 6 19 62	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-1893	
9. AGE (In years if UNDER 1 YEAR; in months and days if UNDER 24 HRS.; in years and months if 24 HRS. to 1 year) 68 yrs.		10. AGE (In years if UNDER 1 YEAR; in months and days if UNDER 24 HRS.; in years and months if 24 HRS. to 1 year) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY St Marys Co. Md.	
11. BIRTHPLACE (County & State or foreign country) St Marys Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barbare		14. MOTHER'S MARRIED NAME Emma M. Dawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Emma M. Washington	
17. INFORMANT Emma M. Washington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-6 , 19 62 , to 4-6 , 19 62 that (I) (we) last saw the deceased alive on 4-6 , 19 62 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED April 7, 1962	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave., Capitol Heights, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62	
23c. NAME OF CEMETERY OR CREMATORY Carmen Memorial Park		23d. LOCATION (City, town or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE 4804 EAGLE HOLLOW RD NORTON MD		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04926

CERTIFICATE OF DEATH

04924

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 4113 Beck St., S.E.		
3. NAME OF DECEASED (Type or print) First Middle Last Ashton M. Hewitt		4. DATE OF DEATH Month Day Year 4 30 19 62		
5. SEX Male		6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1/13/1888		9. AGE (In years last birthday) 74 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker's Helper		10b. KIND OF BUSINESS OR INDUSTRY Cafeway		
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Hewitt		14. MOTHER'S MAIDEN NAME Anna Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 577-12-6145		
17. INFORMANT Decedent		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary hemorrhage 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary tuberculosis (c) DUE TO cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 hr., 9 yrs., 9 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic heart disease				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from 10/10/1952, to 4/30/1962, that (I) (we) last saw the deceased alive on 4/30/1962, and that death occurred at A.M., from the causes and on the date stated above.				
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 4/30/1962		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962		
23c. NAME OF CEMETERY OR CREMATORY Richmond Church Cemetery		23d. LOCATION (City, town or county) (State) Stafford Co. Va.		
24. FUNERAL DIRECTOR'S SIGNATURE F. Saacki Son		25a. REGD BY REGISTRAR DATE MAY 4 '62		
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04927

04925

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> d. STREET ADDRESS <u>2003 Somerset Street</u>			
3. NAME OF DECEASED (Type or print) <u>Ethel GERTRUDE Himelright</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>March 17, 1887</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>15</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Olga Krug. Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42-1</u> DUE TO <u>premature</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary thrombosis</u> DUE TO <u>cardio-vascular</u> (a), stating the underlying cause last. (c) <u>Arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month <u>4</u> Day <u>16</u> Year <u>1962</u> Hour <u>11</u> a.m. <u>19</u> p.m. 20d. INJURY OCCURRED Whole <input type="checkbox"/> Not Whole <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> to <u>4/24</u>, 19<u>62</u>; that (I) (we) last saw the deceased alive on <u>4/24</u>, 19<u>62</u>, and that death occurred at <u>4:10</u>, from the causes and on the date stated above							
22a. SIGNATURE <u>Hei K. Lee</u>				22b. DATE SIGNED <u>4/24</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Hei Kit Lee</u>				22d. ADDRESS <u>P.G.H. 7733 Annapolis Rd. Lanham, Maryland</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-27-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>			
23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>					
25b. REGISTRAR'S SIGNATURE <u>W.M. Chambers Co Riverdale, Md</u>				25c. REGISTRAR'S SIGNATURE <u>Arthur L. James</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04928

04926

M

1. PLACE OF DEATH e. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>27 Maryland Park</u> d. STREET ADDRESS <u>6523 Coolidge Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T</u> Last <u>Hogue Sr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 62</u>			
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>28 Oct. 1887</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired CARPENTER BUILDING</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>			
13. FATHER'S NAME <u>GEORGE W. HOGUE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HUTCHINSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Lower left ventricle)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Left coronary arteriosclerotic occlusion</u> DUE TO (c) <u>Pulmonary edema, bilateral</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> , 19 <u>62</u> to <u>April 21</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 21</u> , 19 <u>62</u> , and that death occurred at <u>1:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William Brainin</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>6124 Central Ave, Capital Hyge Inst</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>BURIAL</u> <u>4-24-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City, town or county) (State) <u>Southland Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. Page 3 should be detached for the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> COUNTY <u>Prince George's</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>513-68th Place (Seat Pleasant)</u>	
3. NAME OF DECEASED (Type or print) <u>Clifford C. Hooker</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-26-1900</u>	
9. AGE (In years, last birthday) <u>61</u> yrs.		10. AGE (In years, last birthday) <u>61</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>Arlington, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Hooker</u>		14. MOTHER'S MAIDEN NAME <u>Mattilda Bear</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Anna B. Hooker</u>	
17. INFORMANT <u>Wife</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 16211 DUE TO <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Metastasis to brain, Lt adrenal gland, Lt kidney.</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>64</u> , to <u>4/23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/23</u> , 19 <u>62</u> , and that death occurred at <u>10:00</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Max M. Herzberg</u>		22b. DATE SIGNED <u>APR 27 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Max M. Herzberg</u>		22d. ADDRESS <u>7016 Greig St., Seat Pleasant, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/26/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE APR 27 '62</u>	
ADDRESS <u>Mt. Rainier Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04930

04928

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admision) a. STATE <u>D. C.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Washington D.C.</u>		<u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor Hospital, LaSalle Rd. 4922</u>		d. STREET ADDRESS <u>2700 Conn. Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Sarah Horlan</u>		4. DATE OF DEATH Month Day Year <u>April 11 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28 1883</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James T. Clements</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Sister Agnes Patricia</u>		Address <u>Carroll Manor</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> DUE TO <u>Cerebral Thrombosis (repeated episodes)</u> DUE TO <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>at death</u> <u>1 week</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2 April 1962</u> to <u>11 April 1962</u> , that (I) (we) last saw the deceased alive on <u>10th April 1962</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Louis A. Craig Jr.</u>	
22b. DATE SIGNED <u>12 April 62</u>		22c. PHYSICIAN'S NAME (Type) <u>LOUIS A. CRAIG, JR. 1746 K ST N.W.</u>	
22d. ADDRESS <u></u>		22e. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/14/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		24b. ADDRESS <u>2224 - Wisconsin Ave NW</u>	
25a. REC'D BY REGISTRAR <u>APR 19 62</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Finner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04931
CERTIFICATE OF DEATH
04929

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u> c. LENGTH OF STAY IN 1b <u>WKS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUITLAND NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DE</u> b. COUNTY <u>DC</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>302 Quade St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET M.</u> First Middle Last 4. DATE OF DEATH <u>April 21 1962</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>JUNE 9 1924</u> Month Day Year 9. AGE (In years, last birthday) <u>37</u> yrs. Months Days Hours M. n. IF UNDER 1 YEAR IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Morgan</u> 14. MOTHER'S MAIDEN NAME <u>BERTHA Boyette</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> 16. SOCIAL SECURITY NO. <u>243-30-1202</u> 17. INFORMANT <u>HOSPITAL RECORDS</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma descending colon</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1960</u> to <u>April 21, 1962</u> that (I) (we) last saw the deceased alive on <u>4/17</u> 1962, and that death occurred at <u>2:00</u> A.M. from the causes and on the date stated above	
22a. SIGNATURE <u>D. Etienne</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Etienne Szollosi M.D.</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2 PARKWAY N. Washington 21-DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-24-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Falls Church Va</u> ADDRESS <u>300 - 4 ST NE WASH DC</u>	
23d. LOCATION (City, town or county) (State) <u>Nat Mem Park Cemetery</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be executed by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04930

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital, 10th and Zug Road
2. USUAL RESIDENCE (Where deceased lived, if institution, Residence basic admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Virginia Howard
4. DATE OF DEATH Month Day Year April 18 19 62
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec. 25, 1902 | 59 yrs. 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Cden Howard Dugan 14. MOTHER'S MAIDEN NAME Rosena Watts
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Lewis Everett Howard, same as # 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary heart disease
(c) Cardiovascular renal disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes of long standing
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ACTUAL SIGNATURE James I. Boyd M.D. ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) James I. Boyd DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED April 18, 1962
Address (Street, city, town or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/21/62 22c. NAME OF CEMETERY OR CREMATORY Any Hill Cem. 22d. LOCATION (City, town, or country) Laurel, Md. (State)
23. FUNERAL DIRECTOR W. W. Carruthers, Laurel, Md. Address
24a. REC'D BY REGISTRAR APR 24 '62 24b. REGISTRAR'S SIGNATURE Arthur E. Harris

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MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04933

04931

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN b 3 1/2 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5110 Logan Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 5110 Logan Street	
3. NAME OF DECEASED (Type or print) CHARLES SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		4. DATE OF DEATH April 10 1962 8. DATE OF BIRTH Sept 26 1908 9. AGE (In years last birthday) 53 yrs 11. BIRTHPLACE (State or foreign country) N.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A./	
13. FATHER'S NAME Manson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none none		14. MOTHER'S MAIDEN NAME Laura Bass 16. SOCIAL SECURITY NO. 577-07-4408 17. INFORMANT Mrs Hattie Hudgins Address Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of Lung DUE TO unknown		INTERVAL BETWEEN ONSET AND DEATH 3 days 9 Mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: None			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James E. Chapman EXAMINER'S NAME (Type) James E. Chapman		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10 Apr 62 Address (Street, city, town, or county) 2026 RST NW Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/62	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or country) (State) Suitland Maryland
23. FUNERAL DIRECTOR Lee Funeral Home Address 300 4th, St. N.E. Washington, D.C.		24a. REC'D BY REG. STRAR APR 13 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Pious	



TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the date and time of the delay in the space provided. This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04934		04932									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>14 Oxon Hill</u>					
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>						d. STREET ADDRESS <u>16317 Dominion Drive</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6317 Dominion Drive</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ernestina Galvez Huici</u>						4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1879</u>		9. AGE (in years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>Spain</u>	
13. FATHER'S NAME <u>Manuel Galvez</u>						14. MOTHER'S MAIDEN NAME <u>Ortega</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miguel Huici, same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Coronary atherosclerosis</u>											
(c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
SIGNATURE <u>James I. Boyd</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>Fort Lincoln, Bladensburg, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL, or other disposition <u>Cremation</u>		22b. DATE THEREOF <u>4/11/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>					
23. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>						24a. REC'D BY REGISTRAR <u>APR 13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04935
04933

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL, ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY DEALE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOX 48 DEALE BEACH d. STREET ADDRESS INMAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) INFANT BOY First Middle 4. DATE OF DEATH APRIL 14 1962 Month Day Year		5. SEX MALE 6. COLOR OR RACE CAUCASIAN 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 APRIL 1962 9. AGE (In years last birthday) 1 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 13. FATHER'S NAME JACK D INMAN		10b. KIND OF BUSINESS OR INDUSTRY NONE 14. MOTHER'S MAIDEN NAME MARY L MILLS		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MARYLAND 12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS, CONGENITAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PREMATURE BIRTH (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 32 HOURS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12 APRIL 1962, to 14 APRIL 1962	
20f. (City or town) 14 APRIL 1962		20g. (County) 14 APRIL 1962		20h. (State) 14 APRIL 1962	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 APRIL 1962 , to 14 APRIL 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 APRIL 1962 , and that death occurred at 4AM , from the causes and on the date stated above.					
22a. SIGNATURE John A Moore M.D. 22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAF MC		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD		22b. DATE SIGNED 14 APRIL 1962	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-18-62		23b. DATE THEREOF 4-18-62		23c. NAME OF CEMETERY OR CREMATORY Arlington Hall	
23d. LOCATION (City, town or county) 7d myer Va		23e. REC'D BY REGISTRAR APR 18 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Hume	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 517-112 SE					



04936

CERTIFICATE OF DEATH

Reg. Dist. No. 04934

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b 16 yrs.		d. STREET ADDRESS 3717-34th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3717-34th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elva Matilda Johannes		4. DATE OF DEATH April 29 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/1882
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Harting		14. MOTHER'S MAIDEN NAME Ida Hoeger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-22-2164	
17. INFORMANT Adeline Forrest - Daughter		Address above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA OF LUNGS, ADVANCED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTERTROCHANTERIC FRACTURE RIGHT FEMUR 6 WKS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> HYPERTENSIVE CARDIO VASCULAR DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/4, 1961, to 4/29, 1962, that I last saw the deceased alive on 4/10, 1962, and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Norman Donat Comeau M.D. 3503 Bay St. 4/30/62 PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU Mt Rainier Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5/2/62	Loudon Park	Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Malleys Funeral Home, Inc.		DATE MAY 3 '62	Carrie S. Kinn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04937

Item 5 from birth certificate

CERTIFICATE OF DEATH

04935

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 42 Hrs. 47 Min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 23 Randall Road • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month Day Year April 5 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 3, 1962	
9. AGE (In years last birthday) 18		10. IF UNDER 1 YEAR Months Days 1 18	
11. IF UNDER 24 HRS Hours Mins. 47		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chaverly Prince George's Co. Md.		11. BIRTHPLACE, County & State, or foreign country Chaverly Prince George's Co. Md.	
13. FATHER'S NAME Harold Eugene Johnson		14. MOTHER'S MAIDEN NAME Wilma Gray Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. Same as above	
17. INFORMANT Mother		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 162.5 DUE TO Bilateral Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162.5 DUE TO Bilateral Atelectasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 162.5	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. TIME OF INJURY Hour a.m. p.m. 19	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 4-3	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-5	
20e. (City or town) 12:05		20f. (County) 4-5	
20g. (State) 19 62		21. I certify that (I) (this hospital) attended the deceased from... 4-3 ... 19... 62 to... 4-5 ... 19... 62 that (I) (we) last saw the deceased alive on 4-5 19 62, and that death occurred at 12:05 from the causes and on the date stated above	
22a. SIGNATURE John W. Perkins		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. John W. Perkins		22d. ADDRESS 5301 Hamilton Street, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/62	
23c. NAME OF CEMETERY OR CREMATORY Johnson Family Burial Plot		23d. LOCATION (City, town or county) Mount Rainier Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Inc.		25a. REC'D BY REGISTRAR APR 9 '62	
25b. REGISTRAR'S SIGNATURE M. Caroline		25c. REGISTRAR'S SIGNATURE Charles E. Prince	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04939
04937

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY (In days) <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Xeland Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>4405-56th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Laura W</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>wh</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>6</u> Day <u>6</u> Year <u>1914</u>		9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tab. Project Planner - Govt. worker</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>William H. Wheatley</u>		16. MOTHER'S MAIDEN NAME <u>Frances Burkhardt</u>		17. SOCIAL SECURITY NO. <u>Informant</u>		18. ADDRESS <u>Hospital Records</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Metastatic Carcinoma to Lungs</u> (c) <u>Carcinoma of Cervix</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>2 months</u> <u>10 months</u>				20. INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 months</u>			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
23a. TIME OF INJURY Hour <u>19</u> e.m. p.m.		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>3 April 1962</u> that (I) (we) last saw the deceased alive on <u>3 April 1962</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.				25. SIGNATURE <u>Thomas M. Hutchin</u> 26. PHYSICIAN'S NAME (Type) <u>Thomas M. Hutchin</u>			
27. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27b. DATE THEREOF <u>4/7/62</u>		27c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		27d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
28. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>				28b. ADDRESS <u>Hyattsville, Maryland</u>		28c. REC'D BY REGISTRAR <u>APR 6 '62</u>	
28d. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				28e. DATE <u>4-4-62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04940

04938

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5571 MAXWELL DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAWN Middle MARIE Last KENNEDY		4. DATE OF DEATH Month APRIL Day 3 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 December 1960
9. AGE (In years last birthday) 1 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) PHILIPPINE ISLANDS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS JAMES KENNEDY		14. MOTHER'S MAIDEN NAME BEATRICE A FREESE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT THOMAS J SMITH (FATHER) SAME AS #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 75 4 5 IMMEDIATE CAUSE (a) Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>3 Apr</u> 1962, to <u>3 Apr</u> 1962, that (I) (the hospital) last saw the deceased alive on <u>3 Apr</u> 1962, and that death occurred at <u>440 P</u> M. from the causes and on the date stated above.			
22a. SIGNATURE John A Moore M.D.		22b. DATE SIGNED 3 APRIL 1962	
22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAF MC		22d. ADDRESS USAF HOSP, ANDREWS AIR FORCE BASE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR 5, 1962	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.		25a. REC'D BY REGISTRAR DATE APR 6 '62	
ADDRESS 577 11th St SE Wash. D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

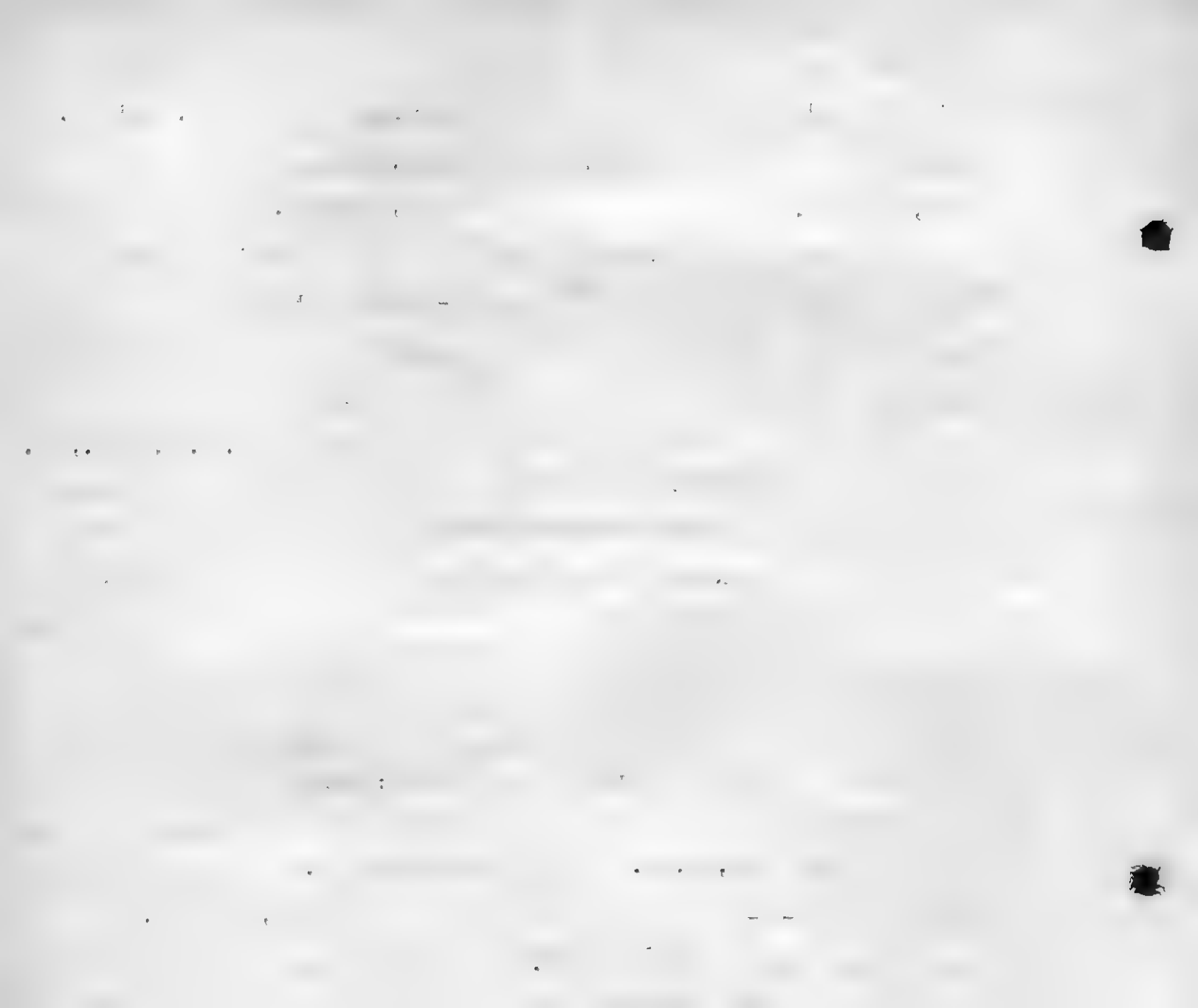


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04941
CERTIFICATE OF DEATH
04939

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton c. LENGTH OF STAY IN 1b 66 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinton, Maryland.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Gee's Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton, Maryland d. STREET ADDRESS Clinton, Maryland. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM BERNARD KING		4. DATE OF DEATH April 17th 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26- 1879	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry King		14. MOTHER'S MAIDEN NAME Adelaide White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.)		16. SOCIAL SECURITY NO.	
17. INFORMANT Cora Murphy 338 - Raleigh St. S. E. Wash., Dc.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO GENERAL ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YEARS YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 15 1961 to APR 17 1962 , that (I) (we) last saw the deceased alive on APR 17 1961 , and that death occurred at 11:25AM the causes and on the date stated above.		22b. DATE SIGNED APRIL 17, 1962	
22a. SIGNATURE Paul Chen, M.D.		22c. PHYSICIAN'S NAME (Type) PAUL CHEN, M. D.	
22d. ADDRESS ACCOKEEK, MD.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April-19-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		25a. REC'D BY REGISTRAR 1962 APR 19	
25b. REGISTRAR'S SIGNATURE John P. Jones		25c. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04942

04940

1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL
c. LENGTH OF STAY IN b. adm 7-17-56
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LAUREL SANITARIUM
e. STREET ADDRESS 3303 N. CHARLES ST.
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS 3303 N. CHARLES ST.
e. DATE OF DEATH 4 27 1962
f. AGE (In years; if under 1 year, last birthday) 4 27 1962
g. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
h. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
i. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
j. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
k. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
l. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
m. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
n. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
o. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
p. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
q. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
r. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
s. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
t. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
u. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
v. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
w. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
x. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
y. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86
z. AGE (In years; if under 1 year, last birthday) 2-14-1876 86 86

3. NAME OF DECEASED (Type or print)
First Middle Last
SAPPY BRUCE KINSON
4. DATE OF DEATH 4 27 1962

5. SEX Female 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-14-1876 9. AGE (In years; if under 1 year, last birthday) 86 10. AGE (In years; if under 1 year, last birthday) 86 11. AGE (In years; if under 1 year, last birthday) 86 12. AGE (In years; if under 1 year, last birthday) 86

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA 11. BIRTHPLACE (County & State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS SEDDON BRUCE 14. MOTHER'S MAIDEN NAME MARY ANDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown 16. SOCIAL SECURITY NO. 108-10-10000 17. INFORMANT Hosp. RECORDS LAUREL SANITARIUM Address LAUREL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac fibrillation (433.1)
DUE TO arteriosclerotic heart disease
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. many yrs
DUE TO undifferentiated pulmonary disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) undifferentiated pulmonary disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) LAUREL SANITARIUM 20f. (City or town) LAUREL (County) PRINCE GEORGE (State) MARYLAND

21. I certify that (I) (this hospital) attended the deceased from 7-17-1956 to 4-27-1962 that (I) (we) last saw the deceased alive on 4-27-1962 and that death occurred at 7:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE Enlon P. Kraemer M.D. 22b. DATE SIGNED 4-27-62
22c. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER 22d. ADDRESS LAUREL SANITARIUM LAUREL MD

23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 4-28-62 23c. NAME OF CEMETERY OR CREMATORY St. Thomas's Church 23d. LOCATION (City, town or county) Garrison, Maryland (State) MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons ADDRESS John O. Mitchell & Sons 25a. REC'D BY REGISTRAR DATE 5-1-62 25b. REGISTRAR'S SIGNATURE Arthur J. Hall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04943

Item 8 Film 4312 5/11/62 mh

04941

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN IB

24 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince Georges

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town,

Riverdale

d. STREET ADDRESS

6314 Patterson Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Henry

Middle

Last

Kumm

4. DATE OF DEATH

Month

Day

Year

A pril

26

19 62

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9 Jan 1963

9. AGE (In years IF UNDER 1 YEAR: IF UNDER 24 HRS. last birthday) Months Days Hours M n.

69 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter Retired

10b. KIND OF BUSINESS OR INDUSTRY

Self

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Kumm

14. MOTHER'S MAIDEN NAME

Elizabeth Essenburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Henry Kumm Jr.

Same as #2 (son)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Garcinoma of prostate

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Possible Right Pulmonary Metastasis

DUE TO

(c)

Bone Metastasis Ilium Bone

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a);

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at..... from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Dr. L. Backrack., M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS

915 19th St., N.W., Washington 6, D.C.

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/30 /62

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln

23d. LOCATION (City, town or county)

Colmar Manor,

(State)

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Francis Marchi Sons

Hyattsville, Md.

DATE MAY 1 '62

Arthur S. Krum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

04944

04942

<p>1. PLACE OF DEATH</p> <p>a. COUNTY Prince Georges County</p> <p>b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly</p> <p>c. LENGTH OF STAY IN MARYLAND 12 Days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE Maryland</p> <p>b. COUNTY Prince Georges County</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville</p> <p>d. STREET ADDRESS 10678 Edmonston Avenue</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>Walter Lampkin</p>		<p>4. DATE OF DEATH April 22, 1962</p>	
<p>5. SEX Male</p> <p>6. COLOR OR RACE White</p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 2-14-13</p> <p>9. AGE (In years, last birthday) 49 yrs. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanic</p> <p>10b. KIND OF BUSINESS OR INDUSTRY W. S. S. C.</p> <p>11. BIRTHPLACE (County & State, or foreign country) Virginia</p> <p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>			
<p>13. FATHER'S NAME Charles Lampkin</p>		<p>14. MOTHER'S MAIDEN NAME Callie Brown</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW 11</p>		<p>16. SOCIAL SECURITY NO. 232-18-3782</p>	
<p>17. INFORMANT Clara M. Lampkin Same as #2 Wife</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANEMIA</p> <p>(b) Chronic Pyelonephritis</p> <p>(c) Hypertensive Cardiovascular Disease</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 3 mos</p> <p>2 yrs</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]</p>	
<p>20c. TIME OF INJURY Month, Day, Year 19</p> <p>Hour a.m. p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town, County, State)</p>	
<p>21. I certify that (I) (th's hospital) attended the deceased from 4-10-1962 to 4-22-1962, that (I) (we) last saw the deceased alive on April 22, 1962, and that death occurred at 6:50 P.M. the causes and on the date stated above.</p>			
<p>22a. SIGNATURE Norman Donat Comenau</p>		<p>22b. DATE SIGNED 4/22/62</p>	
<p>22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMENAU</p>		<p>22d. ADDRESS 3503 PENNYST MT ARLINER MD</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 4/25/62</p>	
<p>23c. NAME OF CEMETERY OR CREMATORY Arlington National</p>		<p>23d. LOCATION (City, town or county) Arlington, Va.</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE Theresa Rose Hyattville, Inc.</p>		<p>25a. REC'D BY REGISTRAR APR 25 '62</p>	
<p>25b. REGISTRAR'S SIGNATURE Arthur S. Kneass</p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



04945

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04943

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL A DREWS		e. STREET ADDRESS A DREWS AFB MD (IAF)	
3. NAME OF DECEASED (Type or print) First THOMAS Middle LEO Last LEONARD		4. DATE OF DEATH Month APRIL Day 22 Year 1962	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 OCTOBER 1939
9. AGE (in years last birthday) 22 yrs		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAILOR		10b. KIND OF BUSINESS OR INDUSTRY US NAVY	
11. BIRTHPLACE (State or foreign country) PE. SYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME RITA LEONARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 174-32-6225	
17. INFORMANT JOSEPH F SPECTER, COUSIN,		Address 931 TURNER AVE DREXEL HILL, PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aplastic Anemia 392.44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 47 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6 Mar 19 62 , to 22 April 19 62 that (I) (we) last saw the deceased alive on 22 April 19 62 , and that death occurred at 9:50 AM , from the causes and on the date stated above			
22a. SIGNATURE Barry Ladd		22b. DATE SIGNED 22 April 1962	
22c. PHYSICIAN'S NAME (Type) BARRY LADD, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL, A DREWS AFB MARYLAND	
23a. BURIAL, CREMATION, REMOVAL OR OTHER BURIAL	23b. DATE THEREOF 4/24/62	23c. NAME OF CEMETERY OR CREMATORY NORWOOD PENNA	23d. LOCATION (City, town, or county) (State) NORWOOD PENNA
24. FUNERAL DIRECTOR'S SIGNATURE Will Chambers Co. Washington		25. REG. STRAR'S SIGNATURE Anthony J. L...	

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 7/59

1
FOR STATE
HEALTH DEPT.

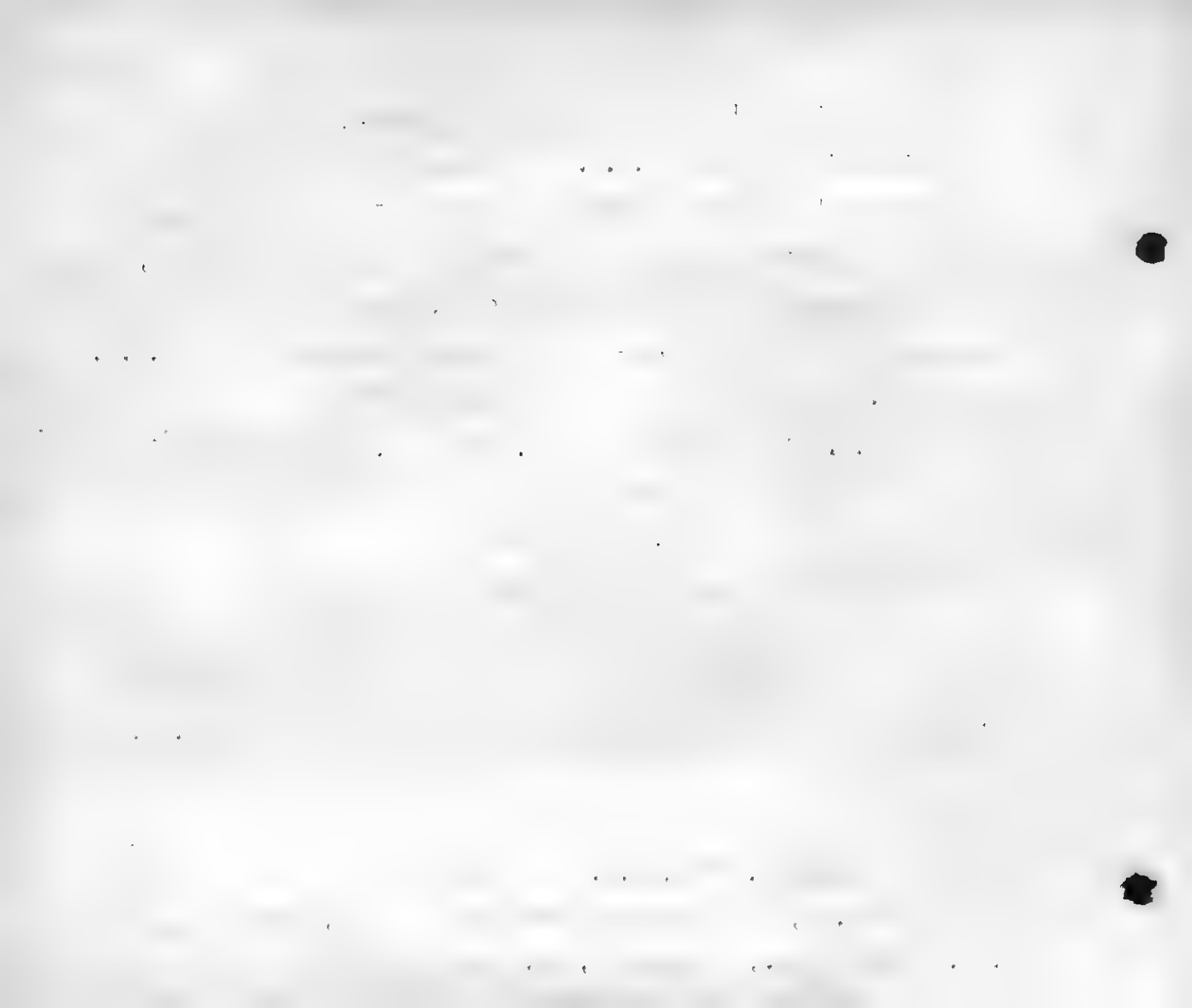
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04944

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 mos. 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Pines d. STREET ADDRESS 6313 Riverdale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Clement John Lindsay	4. DATE OF DEATH April 6 19 62	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-90	9. AGE (in years last birthday) 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George W. Lindsay		14. MOTHER'S MAIDEN NAME Florence Turner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-28-6083		17. INFORMANT Ralph E. Lee 5903 67th Ave. Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PURULENT MENINGITIS DUE TO DECUBITI ULCERS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO FRACURE RT FEMUR PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 1:30 p.m. 12-9-61		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile		20c. TIME OF INJURY Month, Day, Year 12-9-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Riverdale P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) Dr. James I. Boyd		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/62		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D. C.		23. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE APR 12 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hume									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

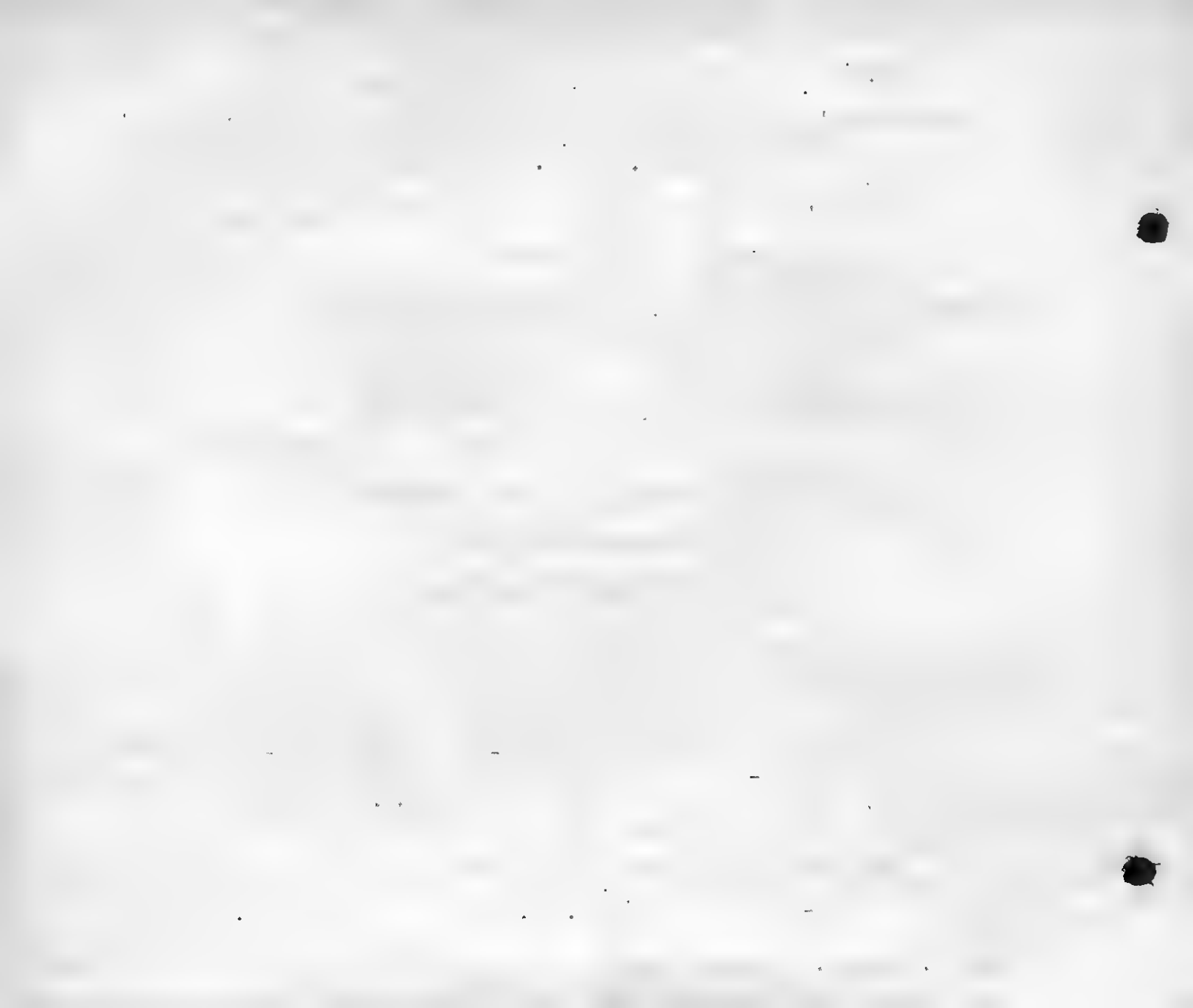
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04948

04946

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden d. STREET ADDRESS 7919 Fiske Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Hrs. 44 Mins.		f. DATE OF DEATH April 5 19 62	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		First Middle Last Baby Girl (A) Lounderman		Month Day Year April 5 19 62	
3. NAME OF DECEASED (Type or print) Baby Girl (A)		4. DATE OF DEATH April 5, 1962		7. AGE (In years last birthday) 2 44	
5. SEX Female		6. COLOR OR RACE Colored		8. DATE OF BIRTH April 5, 1962	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 2 44		10. IF UNDER 1 YEAR Months Days Hours Min. 2 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Graham Lambert		14. MOTHER'S MAIDEN NAME Ida Mae Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Prematurity (c) Pre-mature Labor		19. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr 5 hr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-5 1962 , to 4-5 19 62 that (I) (we) last saw the deceased alive on 4-5 19 62 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Henry A. Wise Jr. M.D. 22c. PHYSICIAN'S NAME (Type) Henry A. Wise Jr.		22b. DATE SIGNED APR 5 1962	
22d. ADDRESS 9005 Volta St, Lanham, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-13-62	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.		25a. REC'D BY REGISTRAR APR 23 '62	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator		25b. REGISTRAR'S SIGNATURE Conrad S. Hines			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04949

04947

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN It 2 Hrs. 42 Mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, street address) 7919 Fiske Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy (B) First Middle Last Louderman		4. DATE OF DEATH Month Day Year April 5 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1962
9. AGE (In years last birthday) 2 42		10. IF UNDER 1 YEAR Months Days Hours Mins. 2 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Graham Lambert		14. MOTHER'S MAIDEN NAME Ida Mae Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Pre-mature labor DUE TO (c) Pre-mature labor PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 5 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 62 to 4-5 , 19 62 , that (I) (we) last saw the deceased alive on 4-5 , 19 62 , and that death occurred at 8:30 , from the causes and on the date stated above.			
22a. SIGNATURE Henry A. Wise Jr. 22c. PHYSICIAN'S NAME (Type) Henry A. Wise Jr.		22b. DATE SIGNED APR 5 1962 22d. ADDRESS 9005 Volta St, Lanham, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-13-62	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.	
24. FEDERAL DIRECTOR'S SIGNATURE Harry W. Poin, Jr., Administrator		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04950

03641

Items 4, 8 & 22 Fill in

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

a. STATE

Maryland

b. COUNTY

Chalres

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Camp Springs

c. LENGTH OF STAY IN IS

DOA

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Waldorf

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Airforce Hospital

M.C.A. Housing Apt 11

3. NAME OF DECEASED (Type or print)

Orsoline

Marie

Lowmiller

4. DATE OF DEATH

April

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years last birthday)

10. UNDER 1 YEAR

11. UNDER 24 HRS

Female

White

WIDOWED

DIVORCED

July

Sept. 24, 1926

35

Yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Kansas

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Virgilio Bonati

14. MOTHER'S MAIDEN NAME

Josephine

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO

17. INFORMANT

Address

Robert Eugene Lowmiller, same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

CEREBRAL HEMORRHAGE

1971.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

HYPERTENSION

DUE TO

(c)

TUMOR OF RIGHT ADRENAL GLAND

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m. p.m.

19

While at work

Not While at work

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 3, 1962

EXAMINER'S NAME (Type)

James I. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATOR

22d. LOCATION (City, town, or county)

(State)

BURIAL

4/6/62

Holy Cross Cemetery

Harrisburg PA.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

W.W. CHAMBERS CO. 5801 CLEVELAND AVE.

DATE APR 6 '62

Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, removal, and any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04951

CERTIFICATE OF DEATH

04948

Item 2 Film 0311 4/17/62

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 1632 Primrose Rd. N.W. 4922/1434118/Road		3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA T. MAHAN		4. DATE OF DEATH Month Day Year April 10 1962							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-16-1896		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days 66		11. IF UNDER 24 HRS. Hours Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Martin Thompson		14. MOTHER'S MAIDEN NAME Elizabeth Rebecca Berry		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) - - - - -	
16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Betty Jane Doyle		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinomatosis 151 X DUE TO (b) Carcinoma rectum Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) - - - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) - - - - -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 mos 4 mos					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) - - - - -		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -		20f. (City or town) (County) (State) - - - - -			
21. I certify that (I) (this hospital) attended the deceased from Nov , 1958, to Apr. 10 , 1962; that (I) (we) last saw the deceased alive on Apr 5 , 1962, and that death occurred at 3:30 PM , from the causes and on the date stated above.		22a. SIGNATURE J. E. Fitzgerald		22b. DATE SIGNED Apr 19 1962		22c. PHYSICIAN'S NAME (Type) J. E. Fitzgerald		22d. ADDRESS Georgetown University Hospital Washington, D. C.		22e. ADDRESS 1756 12th Ave NW Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-1962		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery, Arlington, Va.		23d. LOCATION (City, town or county) (State) - - - - -		24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Quinn		25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04949

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Gen. Hospital
3. NAME OF DECEASED (Type or print) RALPH EUGENE MANUEL
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ B. DATE OF BIRTH July 21, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horseman 10b. KIND OF BUSINESS OR INDUSTRY Horses 11. BIRTHPLACE (State or foreign country) Maine
13. FATHER'S NAME Herbert (n) Manuel 14. MOTHER'S MAIDEN NAME Ida Evelyn Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO No 17. INFORMANT Evelyn G. Manuel 2500 Wusconsin Ave., NW
Address Washington, DC

18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b) and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage and shock
823X DUE TO
Condition which (b) Crushed chest and skull
gave rise to immediate cause (c), stating the underlying cause last. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18
Driver of an automobile that ran off the road and overturned
20c. TIME OF INJURY Month Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
4:30 PM 4/14/62 xx Parkway Greenbelt, P. G. Md
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-18-62 22c. NAME OF CEMETERY OR CREMATORY Washington National Suitland, Maryland
23. FUNERAL DIRECTOR W. W. Chambers & Co. 3022 - M. N. W. 24b. REC'D BY REGISTRAR 24c. REGISTRAR'S SIGNATURE
DATE APR 17 '62



1
FOR STATE
HEALTH DEPT.

04953

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04950

1. PLACE OF DEATH
a. COUNTY **Prince George's** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **DOA**
Prince George's General Hospital
3. NAME OF DECEASED (Type or print) **Agnes Irene McAllister**
4. DATE OF DEATH **April 11, 1962**
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **July 5, 1889** 9. AGE (in years last birthday) **72** yrs IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **House wife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**
13. FATHER'S NAME **John Henry Taylor** 14. MOTHER'S MAIDEN NAME **Sarah Elizabeth Wells**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? **no** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Joseph Henry McAllister Jr.** 4849 Queens Chapel Terr D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Acute congestive heart failure**
DUE TO
Conditions, if any, which gave rise to immediate cause (b) **Arteriosclerotic heart disease**
(a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Diabetes, obesity**
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
SIGNATURE **James I. Boyd** CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **4/11/62**
EXAMINER'S NAME (Type) **JAMES I. BOYD, M.D.** Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF **April 14, 1962** 22c. NAME OF CEMETERY OR CREMATORY **Ford Funeral Home** 22d. LOCATION (City, town, or country) (State) **Bladensburg, Md.**
23. FUNERAL DIRECTOR **Neaf Funeral Home** ADDRESS **4812 Ga An Rd** 24a. REC'D BY REGISTRAR **APR 16 '62** 24b. REGISTRAR'S SIGNATURE **Charles S. Rouse**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Deputy Medical Examiner, or by the Medical Examiner's Office, or by the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. This certificate should be executed in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04951

04951

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) MADISON MONROE NURSING HOME				d. STREET ADDRESS 4330 Valley Terrace St			
3. NAME OF DECEASED (Type or print) First REX Middle - Last McHoney				4. DATE OF DEATH Month April Day 28 Year 1962			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-1889		9. AGE (In years last birthday) 72 yrs	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Christopher McHoney				14. MOTHER'S MAIDEN NAME Levin Maxey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 322-10-0635		17. INFORMANT Glenda B. McClenning Address 4330 Valley Terrace Washington DC			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure 450.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 19, 1962 to April 28, 1962 that (I) (we) lost saw the deceased alive on 4-27-1962 and that death occurred at 6:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Bernard Kutzner				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-28-62	
22c. PHYSICIAN'S NAME (Type) BERNARD KUTZNER				22d. ADDRESS 3520 Mann - Ave - S -			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		5-4-62		Hillville		Hillville MD	
24. FUNERAL DIRECTOR'S SIGNATURE 1. L. L. L.				ADDRESS 3004 7th St		25a. REC'D BY REGISTRAR DATE MAY 3 '62	
						25b. REGISTRAR'S SIGNATURE Charles S. Truena	

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04955		Item 7 Film G311 4/13/62 ink		04952	
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hyattsville</u> c. LENGTH OF STAY in lb <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> d. STREET ADDRESS <u>8521 58 Ave</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth A. McNamara</u>		4. DATE OF DEATH <u>April 4 1962</u>		9. AGE (In years last birthday) <u>78</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1884</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>	
10a. SOCIAL SECURITY NO. <u>076-10-2301</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas McNamara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>076-10-2301</u>		17. INFORMANT <u>ANNA W. McNamara</u> Address <u>SAME AS #2 above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] a. IMMEDIATE CAUSE (a) <u>Generalized abdominal Carcinomatous</u> b. DUE TO <u>Metastasis to Lung</u> c. DUE TO <u>165X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6 1962</u> to <u>April 4 1962</u> , that (I) (we) last saw the deceased alive on <u>3/9/62</u> , and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>W.C. Etienne</u>		22b. DATE SIGNED <u>April 4 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>W.C. ETIENNE</u>	
22d. ADDRESS <u>College Park, Md.</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 9, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Charles Cemetery</u>	
23d. LOCATION (City, town or county) <u>Freeport</u>		23e. (State) <u>New York</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24b. ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		25c. DATE <u>APR 6 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04956

CERTIFICATE OF DEATH

04953

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u>		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>4014 Webster ST.</u>	
3. NAME OF DECEASED (Type or print) <u>BABY BOY MICKLE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>8</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willie James Mickle</u>		14. MOTHER'S MAIDEN NAME <u>MARIAN Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>ATELECTASIA</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> (c) <u>PREMATURITY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>LIFE</u> <u>LIFE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> <u>1962</u> to <u>4-22</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>4-22</u> <u>1962</u> and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>S.V. BATTIATA M.D.</u>		22b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.V. BATTIATA M.D.</u>		22d. ADDRESS <u>7309 RIGGS RD HYATTSVILLE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Fisher</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>		25c. REGISTRAR'S NAME <u>Charles S. Harris</u>	

04954

4952

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY pr geor	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b pr geor	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp'tel, give street address) Southern Maryland		e. STREET ADDRESS 1 Rt 1, Box 649-	
3. NAME OF DECEASED (Type or print) Martha Irene Miller		4. DATE OF DEATH April 4 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH 4 July 1902	
9. AGE (In years, last birthday) 59 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County, State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Rakey		14. MOTHER'S MAIDEN NAME Olivia Garner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Harry F. Miller	
17. INFORMANT Some #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus	
19. WAS AUTOPSY PERFORMED? YES		20. INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... July 1957 to... April 1962 that (I) (we) last saw the deceased alive on... 4/4/62 and that death occurred at... M , from the causes and on the date stated above.		22a. SIGNATURE Alfred R. Lapin	
22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Alfred R. Lapin	
22d. ADDRESS Clinton, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF Removal April 7-62		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
23d. LOCATION (City, town or county) (State) Clinton Maryland		23e. REC'D BY REGISTRAR Arthur S. House	
24. FUNERAL DIRECTOR'S SIGNATURE Samuel B. B...		24b. REGISTRAR'S SIGNATURE Arthur S. House	



1
FOR STATE
HEALTH DEPT.
IM
1
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, give the funeral director, Page 1, 2, and 3 of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RECORDS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04955

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Colmar Manor	
c. LENGTH OF STAY IN b. 10 min.		d. STREET ADDRESS 3406 43rd Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA Schlorb MOCKABEE		4. DATE OF DEATH April 14 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 2, 1895	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Schlorb		14. MOTHER'S MAIDEN NAME Mary Ellen Donaldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 722-05-0339	
17. INFORMANT Paul Francis Mockabee		Address Randolph Village MD 9100 Central Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 442X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. IC (city or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
OFFICIAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER	
NAME (Type) JAMES I. BOYD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		DATE SIGNED 4/14/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-1962	
22c. NAME OF CEMETERY OR CREMATORY Addison Chapel		22d. LOCATION (City, town, or county) (State) Seat Pleasant, Md	
23. FUNERAL DIRECTOR W. W. Chambers & Co Riverdale, Md		24. REC'D BY REGISTRAR APR 17 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04959
04956

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN IT 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9314 - 49th. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Icy Delphia Moore		4. DATE OF DEATH Month April , Day 14 , Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87 11. BIRTHPLACE (County & State, or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Robert W. Moore Address 1322-V-St., S. E. Wash. DC	
16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Congestive Heart Failure 4-2-1 DUE TO (b) Chronic - sclerotic Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH 5 yr +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-13-1962 to 4-14-1962 that (I) (we) last saw the deceased alive on April 14, 1962 , and that death occurred at 9:30 PM on the causes and on the date stated above.			
22a. SIGNATURE W L ETIENNE		22b. DATE SIGNED 4/15/62	
22c. PHYSICIAN'S NAME (Type) W L ETIENNE		22d. ADDRESS College Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 18-62	
23c. NAME OF CEMETERY OR CREMATORY East Hill Cemetery		23d. LOCATION (City, town or county) (State) Salem Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros.		25a. REC'D BY REGISTRAR DATE APR 23 '62	
ADDRESS 1661 - North Ave Rd SE WASH. 20 DC.		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

64960

04957

1. PLACE OF DEATH
a. COUNTY
Prince Georges County

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges County

3. NAME OF DECEASED
(Type or print)
Edna
First Middle Last
MARTHA **Murphy**

4. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital

5. SEX
Female

6. COLOR OR RACE
White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH
1-19-95

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
67 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SUPT. G.S.A.

10b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVTL. RET.

11. BIRTHPLACE (County & State, or foreign country)
WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
ALEXANDER HUMES

14. MOTHER'S MAIDEN NAME
JESSIE FLETCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown), (If yes give year or dates of service)
NO

16. SOCIAL SECURITY NO.
NONE

17. INFORMANT
JOHN D. MURPHY

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Metastatic Brain Tumor**
Conditions, if any, which gave rise to immediate cause (b) **Bilateral Pulmonary Edema**
(c) **Arteriosclerotic Heart Disease**

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
☐

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. **19**

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **April 22, 1962** to **April 25, 1962** that (I) (we) last saw the deceased alive on **April 25, 1962** and that death occurred at **1:00 P.M.** because of causes and on the date stated above

22a. SIGNATURE
Hei K. Lee

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)
Dr. Hei Kit Lee

22d. ADDRESS
7730 Annapolis Rd., Lanham, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
4/30/62

23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL

23d. LOCATION (City, town or county) (State)
ARLINGTON VA.

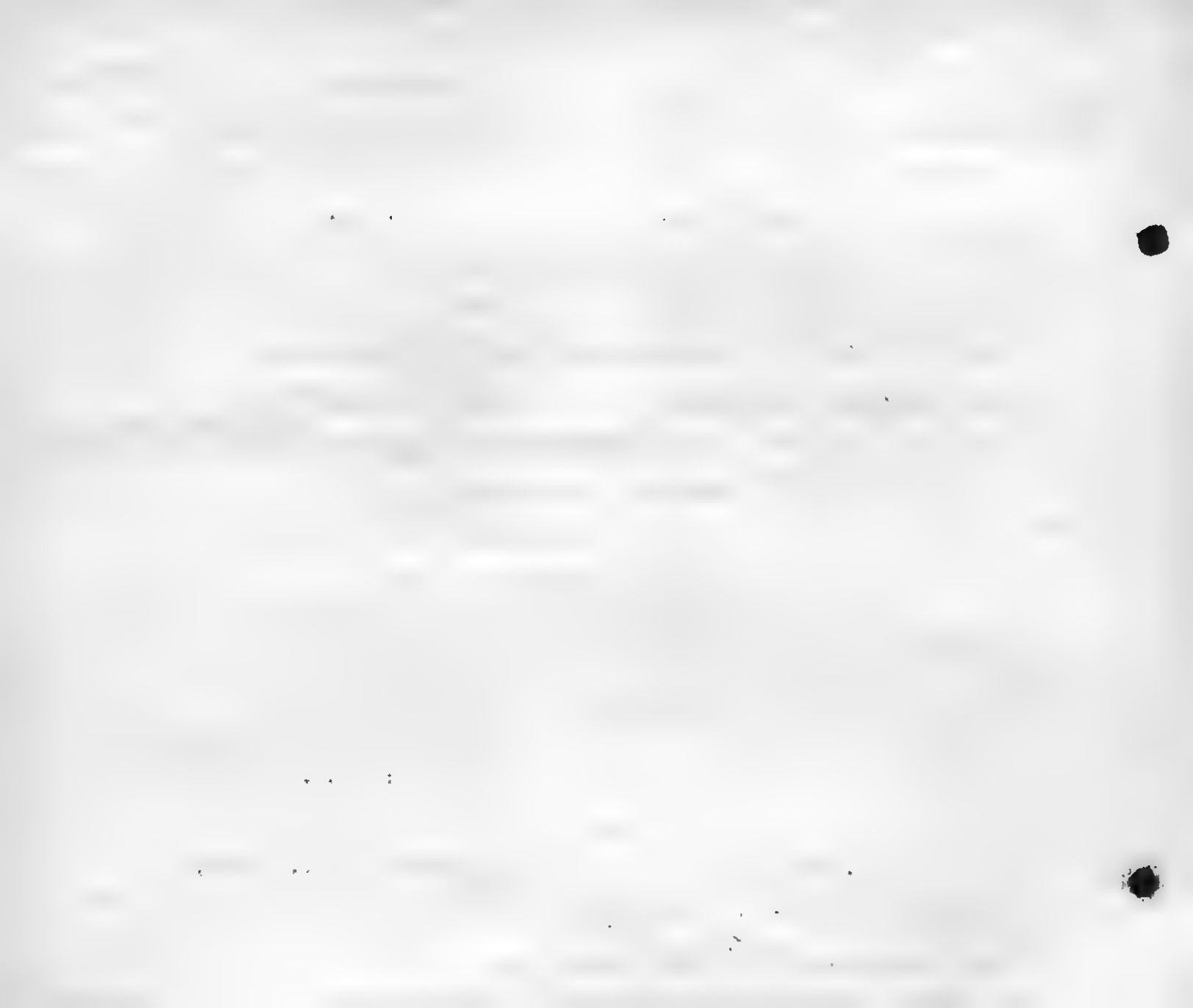
24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co.

25a. REC'D BY REGISTRAR
DATE MAY 2 '62

25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04961

04958

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in lb <u>7 Hrs. 7 Mins.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>569 Hill Road, Huntsville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> 4. DATE OF DEATH <u>April 24 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 24, 1962</u> 9. AGE (In years last birthday) <u>7</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>7</u> Mins. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Prince George's, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Harold Newman</u>		14. MOTHER'S MAIDEN NAME <u>Irene Cecelia Robinson Newman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u> 17. INFORMANT <u>Mother</u> <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac temponade</u> DUE TO (b) <u>Atelectasis of left lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hemothorax left side</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>life</u> <u>life</u> <u>life</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> <u>19 62</u> to <u>4-24</u> <u>19 62</u> , that (I) (we) last saw the deceased alive on <u>4-24</u> <u>19 62</u> , and that death occurred at <u>12:20</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Joseph J. McDonald</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph J. McDonald</u>		22b. DATE SIGNED <u>4/26/62</u> 22d. ADDRESS <u>7309 Riggs Rd., W. Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>May 5, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Geo. Gen. Hospital</u> 23d. LOCATION (City, town or county) <u>Cheverly, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr., Administrator</u> 25a. REC'D BY REGISTRAR <u>DATE MAY 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

04962

CERTIFICATE OF DEATH

Reg. Dist. No. 04959

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prentwood</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prentwood</u>		4b. <u>46</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3717-Shepherd St.</u>		d. STREET ADDRESS <u>3717-Shepherd St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Nuzzo</u>		4. DATE OF DEATH <u>4-30-1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 28 1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government Treasury Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Thomas Virgin Isl. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Thomas Virgin Isl. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Duurloo</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Vaughan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>101-444-2888</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Ovary</u> (c) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ascitis and Pleural effusion</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19 <u>62</u> , to <u>4/29</u> , 19 <u>62</u> that I last saw the deceased alive on <u>4/29</u> , 19 <u>62</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>MARINO SORVILL</u> M.D.		ADDRESS (Street, city or town, state) <u>2802 - Heller. Road Silver Spring, Md.</u>	
DATE SIGNED <u>5/2/62</u>			
PHYSICIAN'S NAME (Type) <u>Marino Sorvill</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Jones</u>	



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04963

CERTIFICATE OF DEATH

04960

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg c. LENGTH OF STAY IN lb 8 mo d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4000-53 ave ST 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMOS CHARLES OGBURN First Middle Last 4. DATE OF DEATH April 5 1962 Month Day Year		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov 7 1874 97 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years) <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. last birthday) Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farm 11. BIRTHPLACE (County & State, or foreign country) Pine Village Ind. USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles William Ogburn 14. MOTHER'S MAIDEN NAME Nancy Ann Shipmon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Mr Roy Ogburn Address 4000 53 ST Bladensburg Md		18. CAUSE OF DEATH (Enter only one cause per line (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral hemorrhage (c) DUE TO Anterior Salivasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a) 4 days INTERVAL BETWEEN ONSET AND DEATH 4 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 8:00 PM..... from the causes and on the date stated above.			
22a. SIGNATURE Dayton O Watkins 22c. PHYSICIAN'S NAME (Type) DAYTON OWATKINS 22d. ADDRESS 5318 annapolis rd Bladensburg Md		22b. DATE SIGNED 4-5-62 22e. REC'D BY REGISTRAR APR 9 '62 22f. REGISTRAR'S SIGNATURE Arthur L. Hines	
23a. BURIAL CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 4/8/1962 23c. NAME OF CEMETERY OR CREMATORY Mummasburg Cemetery 23d. LOCATION (City, town or county) Franklin Twp. Adams Co. Pa. (State)		24. FUNERAL DIRECTOR'S SIGNATURE Gettysburg Penna. 25a. REC'D BY REGISTRAR APR 9 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

04964-
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)	
a. COUNTY	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	a. STATE	b. COUNTY
Prince Georges	MARYLAND	D. C.	
Glenn Dale (rural)	3 months & 11 days	Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Glenn Dale Hospital		1927 Concoran St., N.W.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Joseph C. - O'Neill, Sr.		11 23 1962	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/23/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Unknown		Unknown	
11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pa.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles O'Neill		Father Charashaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
No		Unknown	
17. INFORMANT		Address	
Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of the larynx with metastases			
111X DUE TO			
Conditions, if any, which gave rise to immediate cause (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
Left radical neck dissection, 6/61			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/12/1962, to 4/23/1962, that (I) (we) last saw the deceased alive on 4/23/1962, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Moe Weiss, M.D.		4/23/1962	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Moe Weiss, M.D.		Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		4/27/62	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Cedar Hill Cemetery		Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Robert A. Duppree		APR 30 '62	
25b. REGISTRAR'S SIGNATURE			
Arthur L. Hance			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

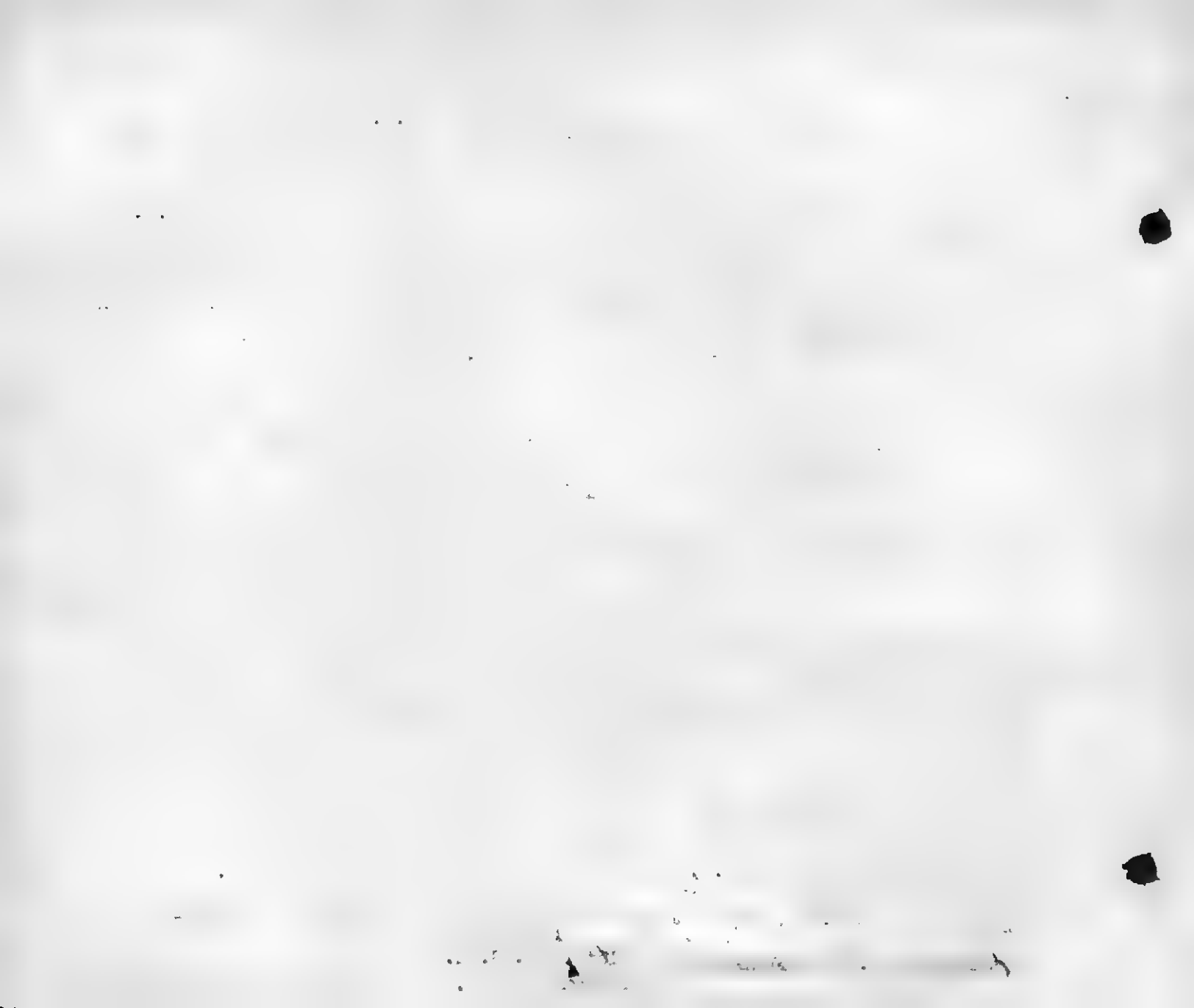
CERTIFICATE OF DEATH

04962

02965

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b <u>6 months and 16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenn Dale Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> d. STREET ADDRESS <u>824 Buchanan St., N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>-</u> Last <u>Parker</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/6/1886</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>19 62</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Scott</u> 14. MOTHER'S MAIDEN NAME <u>Emma Scott</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Elizabeth Parker (daughter)</u> Address <u>unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pulmonary tuberculosis</u> PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> <u>1962</u> to <u>4/1</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> <u>1962</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Moe Weiss</u> 22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Glenn Dale Hospital</u> <u>Glenn Dale, Md.</u> (State) <u>-</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 4, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Johnson Funeral Home</u> 23d. LOCATION (City, town or county) (State) <u>Franklin, Virginia</u>		25a. REC'D BY REGISTRAR <u>APR 6 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Alexander S. Pope</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ALEXANDER S. POPE FUNERAL DIRECTORS</u> <u>414 16th St. S.E.</u> <u>Washington 3, D. C.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04963

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town) Cheverly DOA
c. LENGTH OF STAY IN b Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital 4003 Queensbury Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN, if outside corporate limits write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4003 Queensbury Road

3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Agnes Payne
4. DATE OF DEATH Month Day Year April 21 19 62

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Nov. 8, 1903 9. AGE In years last birthday 58 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 10b. KIND OF BUSINESS OR INDUSTRY Delicatessen 11. BIRTHPLACE (State or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN Welty 14. MOTHER'S MAIDEN NAME Jennie Crim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Betty Jane Knight, Hyattsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Intracerebral Hemorrhage
Conditions, if any, which gave rise to immediate cause (b) DUE TO
(a), stating the underlying cause last. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) James I. Boyd ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED April 21, 1962
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 4-25-1962 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM 22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Maryland 24a. REC'D BY REG STRAR 24b. REGISTRAR'S SIGNATURE
DATE APR 24 '62

TO REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed within 72 hours after death. To execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04967

04964

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b 3 mos. 11 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Box 101		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Mary		Middle L.		Last Payton		4. DATE OF DEATH Month April		Day 26		Year 1962			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-16 1917		9. AGE (In years last birthday) 45 yrs		IF UNDER 1 YEAR Months 4		Days 26		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME William Scrivner		14. MOTHER'S MAIDEN NAME Elizabeth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mary Jackson		Address Upper Marlboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 2nd. & 3rd. degree burns of 35% of body area DUE TO (c) 3 1/2 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Conflagration in the home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home		20c. TIME OF INJURY Hour 2:00 p.m. Month, Day, Year January 16, 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Marlboro, Prince Georges, Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 26, 1962							
ACTUAL SIGNATURE Dr. Paul C. Van Natta		EXAMINER'S NAME (Type) Dr. Paul C. Van Natta		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-62		22c. NAME OF CEMETERY OR CREMATORY Harmony		22d. LOCATION (City, town, or country) Highland Park		(State) Md.			
23. FUNERAL DIRECTOR Myrtle K. Rollins		ADDRESS 4339 Hunt Pl. N.E.		24a. REC'D BY REGISTRAR MAY 2 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

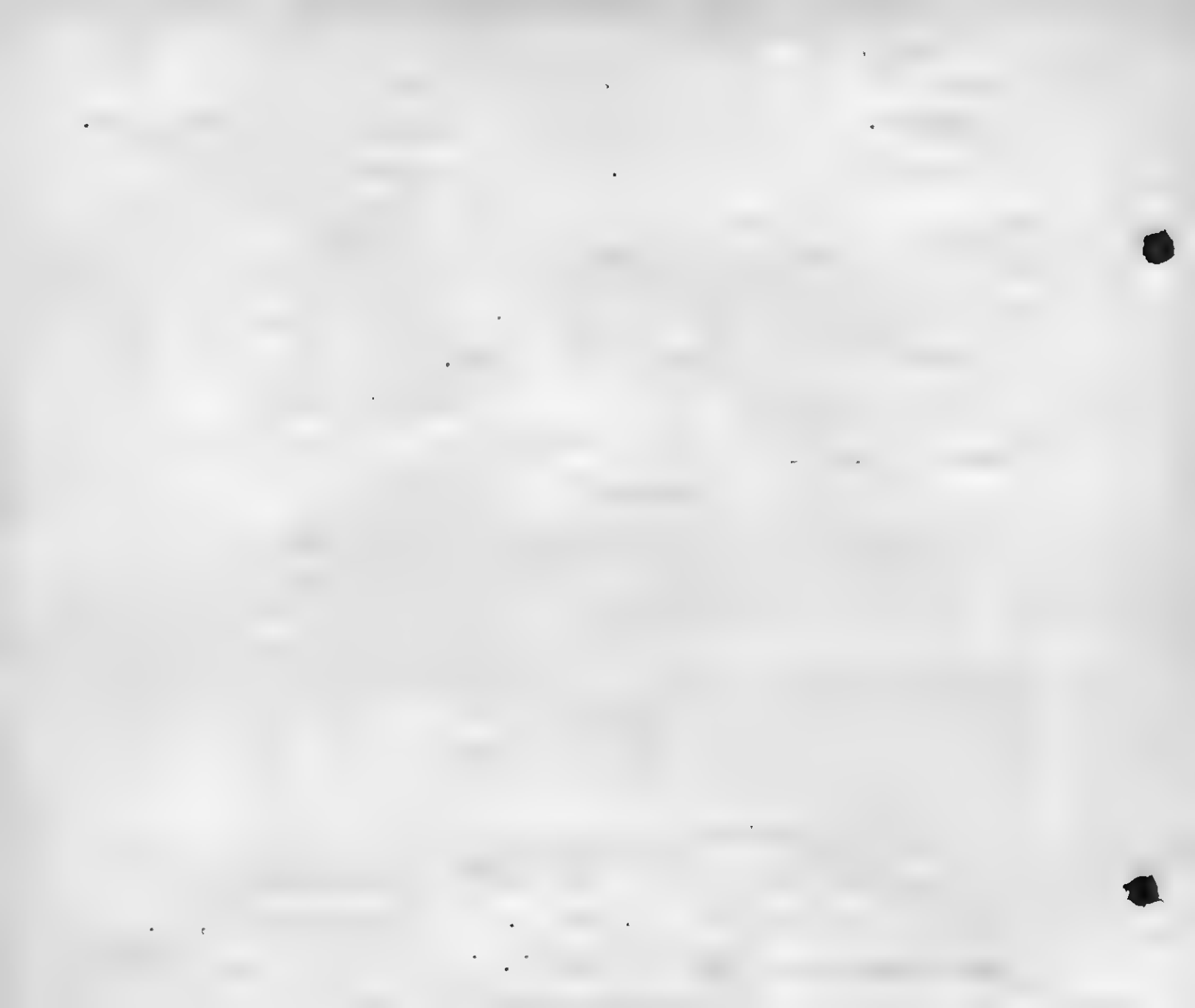
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04968

04965

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville c. LENGTH OF STAY IN b. 50 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle Nelson Last Peach 4. DATE OF DEATH Month April Day 18 Year 1962		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 13, 1882 9. AGE (In years) 79 yrs. IF UNDER 1 YEAR: Months 7 Days 18 Hours 18 Min. IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Jones Nelson 14. MOTHER'S MAIDEN NAME Anne Rebecca Englar		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Preston Peach Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cachexia DUE TO (b) Adeno carcinoma of stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 2 mos 6 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... Oct. 16, 1962 to... 18 Apr 1962 that (I) (we) last saw the deceased alive on... 14 Apr 1962 and that death occurred at... 2:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R.B. Sasser 22c. PHYSICIAN'S NAME (Type) R. B. Sasser		22b. DATE SIGNED 22d. ADDRESS MARLBORO, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21 April 1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cem.		23d. LOCATION (City, town or county) Mitchellville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gasch Funeral Home		25. REC'D BY REGISTRAR APR 24 '62	
25b. REGISTRAR'S SIGNATURE			



04959

04966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN (b)
D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Kent Village
d. STREET ADDRESS
7220 Euclid St.
e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
Albert William Peters
5. SEX
Male
6. COLOR OR RACE
White
7. MARRIAGE STATUS
☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED
8. DATE OF BIRTH
January 22, 1920
9. AGE in years (last birthday)
42
10. IF UNDER 1 YEAR
Months Days
11. IF UNDER 24 HRS.
Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Yard helper
10b. KIND OF BUSINESS OR INDUSTRY
B&O RR
11. BIRTHPLACE (State or foreign country)
Pennsylvania
12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Phillip Fulmer Peters

14. MOTHER'S MAIDEN NAME

Florence May Kirkland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW 11
16. SOCIAL SECURITY NO
210077008
17. INFORMANT
Thelma Dotson Peters, same as # 2
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO (b) CORONARY ARTERY OCCLUSION
DUE TO (c) HEMORRHAGE OF ATHEROMATOUS PLAQUE
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED
4/12/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

4-16-1962 FORT LINCOLN CEM

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR

W.W. Chambers Co. Riverdale, Md

24a. REC'D BY REGISTRAR

DATE APR 17 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Hanna

TO: CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death delay is necessary. To execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04970
04967

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 55 minutes		8. STREET ADDRESS 5116 Flintridge Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH April 26 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 26, 1962	
9. AGE (In years last birthday) 76 1/5		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gordon A. Peters		14. MOTHER'S MAIDEN NAME Ruth Virginia Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 76 1/5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Umbilical cord tight around neck		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26 1962, to 4-26 1962, that (I) (we) last saw the deceased alive on 4-26 1962, and that death occurred 9:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE John Kehoe		22b. DATE SIGNED 5-2-62	
22c. PHYSICIAN'S NAME (Type) Dr. John Kehoe		22d. ADDRESS 6300 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/5/62	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR MAY 8 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

2-646-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04971
04968
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adalphi Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adalphi	
c. LENGTH OF STAY IN 1b 3 Hr		d. STREET ADDRESS 2515 Buck Lodge Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice P Powell		4. DATE OF DEATH Month Day Year Apr. 22 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1888
9. AGE (In years, months, days) 73 yrs.		10. IF UNDER 1 YEAR: Months Days 11. IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Brooklyn N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlton Prankard		14. MOTHER'S MAIDEN NAME Martha C Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-44-2699	
17. INFORMANT Marshall Powell		Address Adelphi, Md. (Son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Congestive Heart Failure Myocardial Fibrosis DUE TO Coronary Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (II) (the hospital) attended the deceased from March 19, 1962 to April 22, 1962, that (I) (we) last saw the deceased alive on April 22, 1962, and that death occurred at 4:00 PM, from the causes and on the date stated above			
22a. SIGNATURE R.D. Bauer, M.D.		22b. DATE SIGNED 4-22-62	
22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.		22d. ADDRESS 2513 Buck Lodge Road, Adelphi, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 24 1962	
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City, town or county) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pearson Funeral Home		25a. REC'D BY REGISTRAR DATE APR 25 '62	
ADDRESS Falls Church, Va.		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04972

CERTIFICATE OF DEATH

04969

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lothian</u> d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewis</u> First <u>H</u> Middle <u>Priset</u> Last		4. DATE OF DEATH Month <u>4</u> - Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>	
11. IF UNDER 24 HRS. Hours <u>11</u> Min <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empl'd Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wellsboro, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Priset</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Shaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>Mrs. Margaret Cox</u> Address <u>Lothian, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>526X Bronchial Pneumonia</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Chronic Lung Disease (Bronchitis)</u> DUE TO		<u>27 yrs.</u>	
(c) <u>Hypertensive Cardiovascular Disease with Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-26-62</u> , 19 <u>62</u> to <u>4-29-62</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4-29-62</u> , 19 <u>62</u> ; and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Waldo B. Moyer</u> M.D.		22b. DATE SIGNED <u>4-29-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Waldo B. Moyer</u>		22d. ADDRESS <u>3503 Perry St. Mt. Rainier Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wellsboro Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Wellsboro, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 7 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

04973

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04970

1. PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Riverdale
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Leland Memorial Hospital

3. NAME OF DECEASED
(Type or print)

Andrew Leo Radcliffe

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Monocaster (Retired)

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov't. District of Columbia

13. FATHER'S NAME

Jesse Radcliffe

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

b. COUNTY

Washington

c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

300 Gallatin St., N.W.

DATE OF DEATH

April 29, 1962

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

58 yrs. Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Fannie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give year or date of service)

No

16. SOCIAL SECURITY NO

Unknown Florence Jackson Radcliffe, 119 You St. N.E.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

812X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

LACERATIONS, SPINAL CORD
FRACTURED CERVICAL VERTEBRAE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Struck by car while walking on Boulevard

20c. TIME OF INJURY Month, Day, Year

10:45 p.m. 4/29 1962

20d. INJURY OCCURRED

While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

U.S. Rte. #1

20f. City or town

Murkirk

(County)

P.G.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Paul C. Van Natta

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/30/62

EXAMINER'S NAME (Type)

PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

5.4.62

22c. NAME OF CEMETERY OR CREMATORY

MT. OLIVET CEMETERY

WASHINGTON, D.C.

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

William H. Smith

ADDRESS

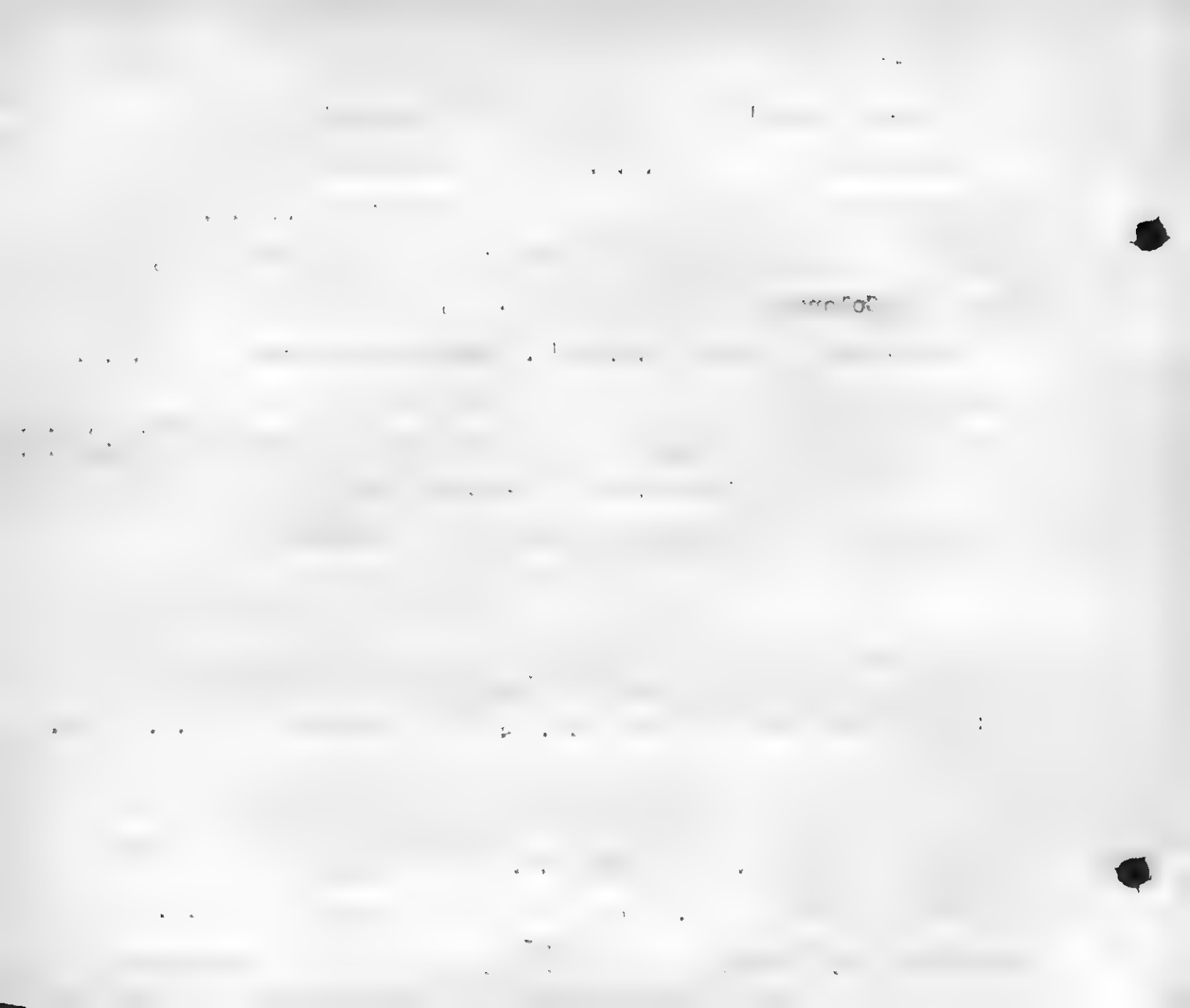
1870-9th Wash. D.C.

24a. REC'D BY REGISTRAR

DATE MAY 3 '62

24b. REGISTRAR'S SIGNATURE

Arthur P. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

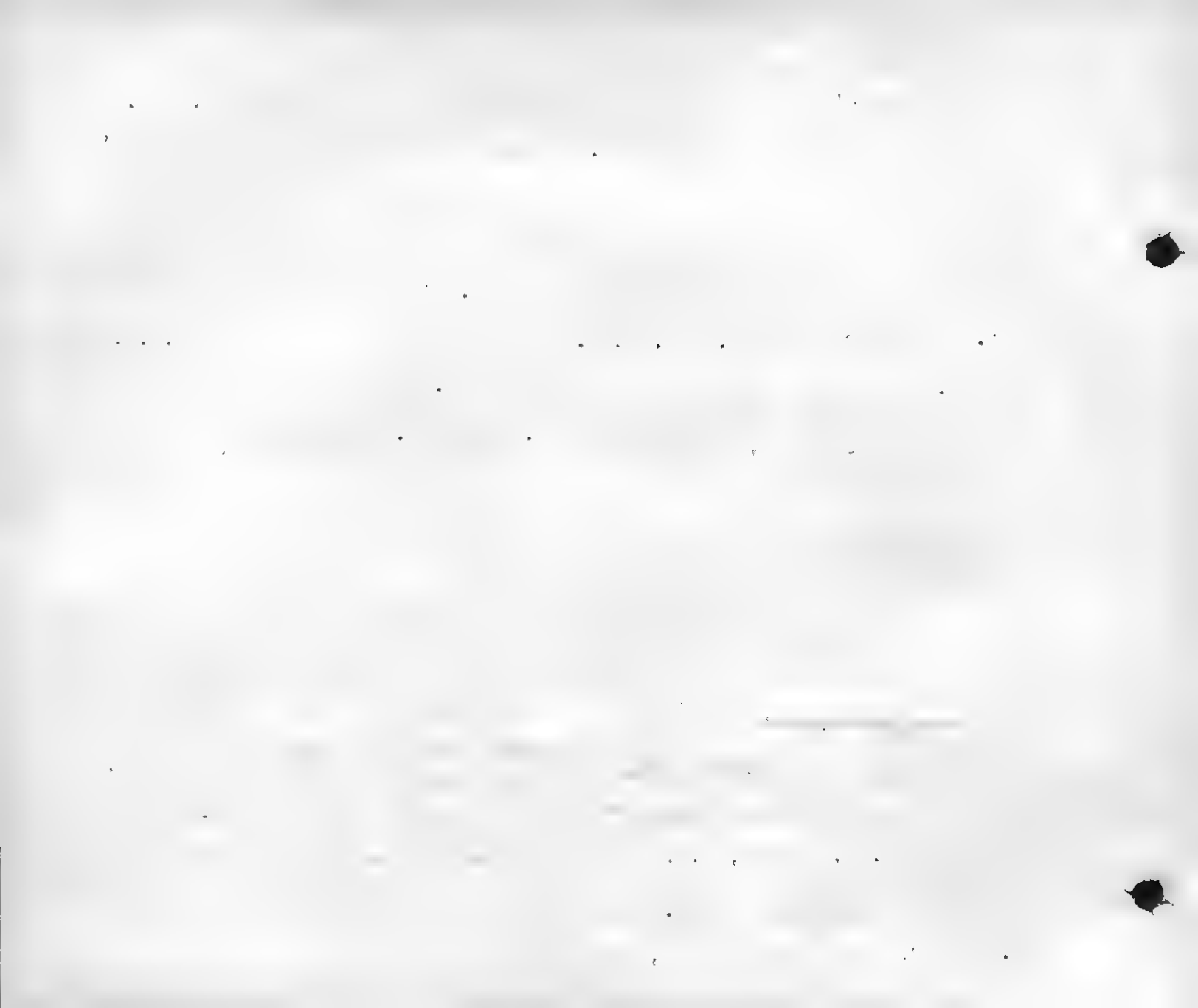
04971

04974

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale		c. LENGTH OF STAY IN 1b 14 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2025 Woodreeve Road		d. STREET ADDRESS 2025 Woodreeve Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM LESTER RICHARDS		4. DATE OF DEATH Month April Day 11 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Oct. 1867
9. AGE (In years last birthday) 94 yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 705100060	
17. INFORMANT Mrs. Billie J. Cain		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GANGRENE OF FEET DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 		INTERVAL BETWEEN ONSET AND DEATH 15 DAYS 20 YRS. (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 8-12-62		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 5, 1957 to APR. 11, 1962 that (I) (we) last saw the deceased alive on APR. 9, 1962 and that death occurred 8:55 A.M. from the causes and on the date stated above			
22a. SIGNATURE J. E. Bowman M.D.		22b. ADDRESS 4021 - 18TH ST., N.E.	
22c. PHYSICIAN'S NAME (Type) J. E. Bowman, M.D.		22d. ADDRESS 4021 - 18TH ST., N.E.	
23a. BURIAL, CREMATION, or other (Specify) Burial		23b. DATE THEREOF 4/12/62	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR APR 16 '62	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

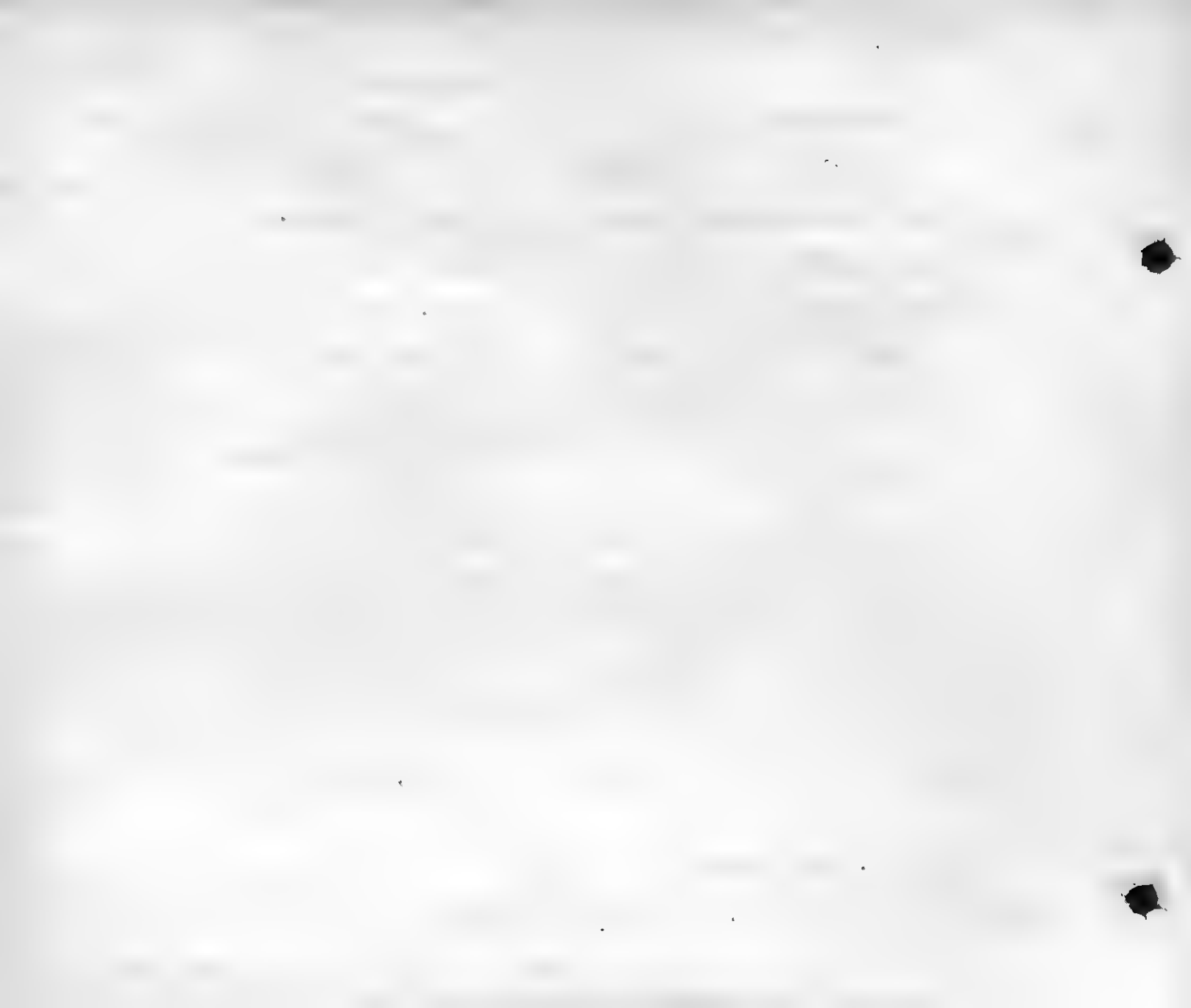
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04975

04972

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Cottage City			
c. LENGTH OF STAY IN 1b 3 days				d. STREET ADDRESS 3803 37th Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry M Richardson				4. DATE OF DEATH April 25 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Dec. 1889	
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State or foreign country) Paterson N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Richardson				14. MOTHER'S MAIDEN NAME Virginia ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. above			
17. INFORMANT Mary G. Richardson, wife				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart disease (c) Bilat. pulm. congestion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 22nd , 1962, to Apr 28th , 1962, that (I) (we) last saw the deceased alive on Apr 28th , 1962, and that death occurred at 6:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Toll Bergemann				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Toll Bergemann				22d. ADDRESS 53A Crescent Road Greenbelt			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Inc.				25a. REC'D BY REGISTRAR DATE 4/30/62		25b. REGISTRAR'S SIGNATURE Arthur L. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04976 CERTIFICATE OF DEATH 04973

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) AD SACORDA NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VA b. COUNTY ALEXANDER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ALEXANDER d. STREET ADDRESS 310 ORVILLE ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA A. ROBERTSON First Middle Last 4. DATE OF DEATH APRIL 14 1962 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH SEP 26 1878 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (County & State or foreign country) PRINCE GEORGE'S COUNTY MD 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE DENNISON 14. MOTHER'S MAIDEN NAME ALICE SUMMERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT GLADYS E HOLDEN Address 2230 Keamy St SE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 Jan 1962 to 13 April 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 7 A M, from the causes and on the date stated above.			
22a. SIGNATURE John K. Hogue 22c. PHYSICIAN'S NAME (Type) John K E HOGUE		22b. DATE SIGNED 14 April 1962 22d. ADDRESS 6300 RIVERDALE RD RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4/17/62		23c. NAME OF CEMETERY OR CREMATORY ADDISON CHAMBERLAIN 23d. LOCATION (City, town or county) (State) SEMI PRINCE GEORGE MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers G ADDRESS 517-11 ST SE		25a. REC'D BY REGISTRAR APR 17 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04977

CERTIFICATE OF DEATH

04974

1. PLACE OF DEATH
a. COUNTY **Prince Georges** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN 1b **40 min**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Prince Georges General Hospital**
3. NAME OF DECEASED (Type or print) First **Baby** Middle **Girl** Last **Robinson**
4. DATE OF DEATH Month **April** Day **16** Year **19 62**
5. SEX **Female** 6. COLOR OR RACE **Black** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **16 April 1962**
9. AGE (In years last birthday) **0** 10. BIRTHPLACE (County & State, or foreign country) **Maryland**
11. CITIZEN OF WHAT COUNTRY? **U.S.A.**
12. CITIZEN OF WHAT COUNTRY? **U.S.A.**
13. FATHER'S NAME **Roland F**
14. MOTHER'S MAIDEN NAME **Maryl Helen Jenkins**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **None**
16. SOCIAL SECURITY NO. **17. INFORMANT** **Mother** **Same as above**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Pulmonary Atelectasis**
DUE TO **762.0**
Condo .., if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Possible dermoid tumor of neck**
DUE TO (c)
PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **4/16/62** 20d. INJURY OCCURRED While ☐ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** **19 62 to 4/16/62** (County) (State)
21. I certify that (I) (this hospital) attended the deceased from **4/16/62** to **4/16/62**, 19 **62**, that (I) (we) last saw the deceased alive on **4/16/62**, and that death occurred at **2:50A M** from the causes and on the date stated above.
22a. SIGNATURE **Salvatore Battiatto, M.D.** 22b. DATE SIGNED **4/16/62**
22c. PHYSICIAN'S NAME (Type) **Salvatore Battiatto, M.D.** 22d. ADDRESS **7309 Reg Rd - Hyattsville**
23a. BURIAL, CREMATION, REMOVAL (Specify) **Cremation** 23b. DATE THEREOF **May 5, 1962** 23c. NAME OF CEMETERY OR CREMATORY **Prince Geo. Gen. Hospital** 23d. LOCATION (City, town or county) **Cheverly, Md.** (State)
24. FUNERAL DIRECTOR'S SIGNATURE **Harry W. Penn, Jr., Administrator** 25a. REC'D BY REGISTRAR **MAY 8 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Hines**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04978 **04975**

1. PLACE OF DEATH
a. COUNTY **Prince George's** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Riverdale** **D.O.A.**
c. LENGTH OF STAY IN b. **Berwyn Heights**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Leland Memorial Hospital**
e. STREET ADDRESS **8914 59th., Avenue**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Maryland** b. COUNTY **Prince George's**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Berwyn Heights**

3. NAME OF DECEASED (Type or print) **Lucian Rodriguez**
4. DATE OF DEATH **April 25, 1962**
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Jan 8, 1895**
9. AGE in years (last birthday) **67** yrs. 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) **Porto Rico** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Unknown Rodriguez** 14. MOTHER'S MAIDEN NAME **Unknown**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **Yes W.W. 1** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Ludwig George Rodriguez, 8219 16th. Ave., Hyattsville, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Acute coronary Occlusion**
420.1 DUE TO (b) **Chronic Coronary Vascular disease**
Conditions, if any, which gave rise to immediate cause (c) **General arteriosclerosis**
(e), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **None that I know**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH. **None**
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) **None**
20c. TIME OF INJURY Month Day Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **None** 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED **4/26/62**

ACTUAL SIGNATURE **Paul C. Van Natta**
EXAMINER'S NAME (Type) **Paul C. Van Natta, M.D.**
Address (Street, city, town, or county) **W.W. Chambers Co. Riverdale, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **5-1-62** 22c. NAME OF CEMETERY OR CREMATORY **Arlington National** 22d. LOCATION (City, town, or country) (State) **Arlington Virginia**

23. FUNERAL DIRECTOR **W.W. Chambers Co. Riverdale, Md.** ADDRESS **8914 59th., Avenue**
24a. REC'D BY REGISTRAR **APR 30 '62** 24b. REGISTRAR'S SIGNATURE **Arthur L. Frank**



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS					c. LENGTH OF STAY IN 1b 4 DAYS				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1800 St Marks Place					d. STREET ADDRESS FAIRFAX VIRGINIA				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, ANDREWS AIR FORCE BASE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NORMAN ELLIOTT ROGERS					4. DATE OF DEATH Month APRIL Day 20 Year 19 62				
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 26 1887		9. AGE (in years lost birthday) 74 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY HEATING		11. BIRTHPLACE (State or foreign country) AVONDALE, Pa		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EBONEZER ROGERS					14. MOTHER'S MAIDEN NAME ELLIOTT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 578072120				
					17. INFORMANT Address 1800 St Marks Pl (Son) Col Norman Rogers, Jr. Fairfax, Va.				
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Collapse 151X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Gastric Carcinoma DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH less than 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A				
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from 17 April 19 62 to 20 April 19 62 that it (we) last saw the deceased alive on 20 April 19 62 and that death occurred on 20 April 19 62 at 6:55 PM from the causes and on the date stated above									
22a. SIGNATURE <i>Stanley R. Payne</i>					22b. DATE SIGNED 20 April 62				
22c. PHYSICIAN'S NAME (Type) STANLEY R. PAYNE, LT USN, MC					22d. ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AFB, MD.				
23a. BURIAL <input checked="" type="checkbox"/> REMOVAL (Specify)		23b. DATE THEREOF 4/24/62		23c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Phyllis M. Morn</i> ARLINGTON FUNERAL HOME					25a. REC'D BY REGISTRAR ADDRESS 3901 NO FAIRFAX DRIVE ARLINGTON 3/VA.		25b. REGISTRAR'S SIGNATURE <i>Cynthia S. Kline</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e... within 24 hours after
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04980

CERTIFICATE OF DEATH

04977

1. PLACE OF DEATH
a. COUNTY Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b. MARYLAND 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cedar Heights
d. STREET ADDRESS 30 1 915 64th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) Baby Girl "B" Ross
4. DATE OF DEATH April 29 1962
5. SEX Female
6. COLOR OR RACE Black
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 28 April 1962
9. AGE (In years last birthday) yrs. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Edward Ross
14. MOTHER'S MAIDEN NAME Wilma Mayo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7545 DUE TO Congenital Heart Disease
(b) Bilateral Pulmonary Atelectasis
(c) Prematurity (Twin) B
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/28 1962 to 4/29 1962, that (I) (we) last saw the deceased alive on 4/29 1962, and that death occurred at 7:30 PM from the causes and on the date stated above
22a. SIGNATURE Dr. Salvatore Battiatto
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Salvatore Battiatto
22d. ADDRESS 7309 Riggs Rd., Hyattsville, Maryland
22e. ATTENDING PHYS. MED. DIRECTOR ☐ STAFF PHYS. ☒
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE THEREOF 5/4/62
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.
23d. LOCATION (City, town or county) Cheverly, MD. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator
25a. REC'D BY REGISTRAR DATE MAY 8 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

Harry W. Penn, Jr., Administrator

2-046558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item 8 11m 4312 3/7/62 iwc 04978

1. PLACE OF DEATH
a. COUNTY Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland
c. LENGTH OF STAY in 1b 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suitland Nursing Home, Inc

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY D.C.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 5303 Valley Rd., S.E.

3. NAME OF DECEASED (Type or print)
First Theodosia Middle Roundabout Last
4. DATE OF DEATH April 26, 19 62
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 5/4/1896 1894 67 yrs.
9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME Henry Moore 14. MOTHER'S MAIDEN NAME Curry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Eleanor Smith, 5303 Valley Rd., S.E., Washington 27, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis
Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 22, 1962, to April 26, 1962, that (I) (we) last saw the deceased alive on April 25, 1962, and that death occurred at 6:25 A.M. from the causes and on the date stated above.
22a. SIGNATURE Frank S. Pellegrini M.D. 22b. DATE SIGNED 4/26/62
22c. PHYSICIAN'S NAME (Type) Frank S. Pellegrini 22d. ADDRESS 3409 Ala Ave SE

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF April 30-62 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Seminars Bros 1661 Good Hope Rd SE
25a. REC'D BY REGISTRAR DATE APR 30 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G-12 5/16/62 iwk

04979

1. PLACE OF DEATH
a. COUNTY

Prince George County MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.C.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George Hospital

3. NAME OF DECEASED
(Type or print)

First Alfred

Middle Tennyson

Last Rowley

5. SEX

Male

White

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Nov. 10, 1911

9. AGE (In years last birthday)

50 yrs.

4. DATE OF DEATH

Month April

26 day

Year 1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

New York

13. FATHER'S NAME

Samuel Rowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO

217-05-4891 Mrs. Ruth Rowley - - Same as 2d.

14. MOTHER'S MAIDEN NAME
Unknown (Wife)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a):

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Acute Coronary Occlusion

Coronary Vascular Disease

DUPLICATE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

None that I know

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Natural Causes

20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL SIGNATURE

Dr. Paul C. Van Natta

EXAMINER'S NAME (Type)

Dr. Paul C. Van Natta

Address (Street, city, town, or county)

April 27, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 4/30/62

22b. DATE THEREOF

Fort Lincoln

22c. NAME OF CEMETERY OR CREMATORY

Colmar Manor, Md.

23. FUNERAL DIRECTOR

Malley's Funeral Home Inc.

ADDRESS

Mt. Rainier Md.

24a. REC'D BY REGISTRAR

DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE

Charles E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if last 1 yr; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4310 Baltimore Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Royal		4. DATE OF DEATH April 16 1962	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 14 April 1962		9. AGE (in years last birthday) yrs. 2 IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min. 2 IF UNDER 24 HRS: Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clifford Arden Royal		14. MOTHER'S MAIDEN NAME Donetta Lee Wilkes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clifford Royal		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Prematurity - with Immaturity Conditions, if any, which gave rise to immediate cause (b) Respiratory Distress Synd - (a), stating the underlying cause last. (c) 1	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from April 14, 1962 to April 16, 1962 , that (I) (we) last saw the deceased alive on April 16, 1962 , and that death occurred at 11:15 PM from the causes and on the date stated above.		22. SIGNATURE Dr. Salvatore Battiatto 22c. PHYSICIAN'S NAME (Type) Dr. Salvatore Battiatto	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/62	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town or county) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Alfred S. Buglio		25a. REC'D BY REGISTRAR APR 19 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS Hyattsville Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04981

1. PLACE OF DEATH a. COUNTRY <u>PRINCE GEORGE MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN 1b <u>admn. 8-13-1960</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL SANITARIUM</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u> d. STREET ADDRESS <u>3909 Woodbine Street</u>	
3. NAME OF DECEASED (Type or print) <u>JANET S. RUTTER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>5</u> Day <u>16</u> Year <u>1874</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
10a. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>UNKNOWN</u>		13. MOTHER'S MAIDEN NAME <u>HENRIETTA BARNES</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		15. SOCIAL SECURITY NO. <u>17</u>	
16. INFORMANT <u>Mrs. Charles M. Little, (Daughter)</u>		17. ADDRESS <u>500</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>500X</u> DUE TO <u>Ante mortem (parental)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>500X</u> DUE TO <u>500</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-13-</u> 19 <u>60</u> to <u>4-24-</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-24-</u> 19 <u>62</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Indee P. Kraemer</u>		22b. DATE SIGNED <u>4-24-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		22d. ADDRESS <u>LAUREL SANITARIUM LAUREL MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>14-28-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sewler's Sons</u>		25a. REC'D BY REGISTRAR <u>APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>		25c. ADDRESS <u>Washington, D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04985

04982

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES , MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b 2 1/2	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		d. STREET ADDRESS 3507 79th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle Joy Last Sanger		4. DATE OF DEATH Month April Day 13 Year 1962	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Feb 1962
9. AGE (n years lost birthday) 2 yrs.		IF UNDER 1 YEAR: Months 2 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Applicable		10b. KIND OF BUSINESS OR INDUSTRY Not Applicable	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Sanger		14. MOTHER'S MAIDEN NAME Mildred (NMI) Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Not applicable	
17. INFORMANT BENJAMIN SANGER		Address 3507 79TH AVE FORESTVILLE, MD	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mongolism DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 April 1962 to 13 April 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 2208M , from the causes and on the date stated above.			
22a. SIGNATURE John A. Moore M.D.		22b. DATE SIGNED 13 April 1962	
22c. PHYSICIAN'S NAME (Type) John A. Moore		22d. ADDRESS 5571 Auth Road Camp Springs, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) SURIAL	23b. DATE THEREOF 4/16/62	23c. NAME OF CEMETERY OR CREMATORY D. C. LODGE CEM	23d. LOCAT ON (City town or county) (State) WASH., DC
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. [unclear]		25a. REC'D BY REGISTRAR 10R 17 '62	
ADDRESS 4217-9th ST. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. [unclear]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, I will execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

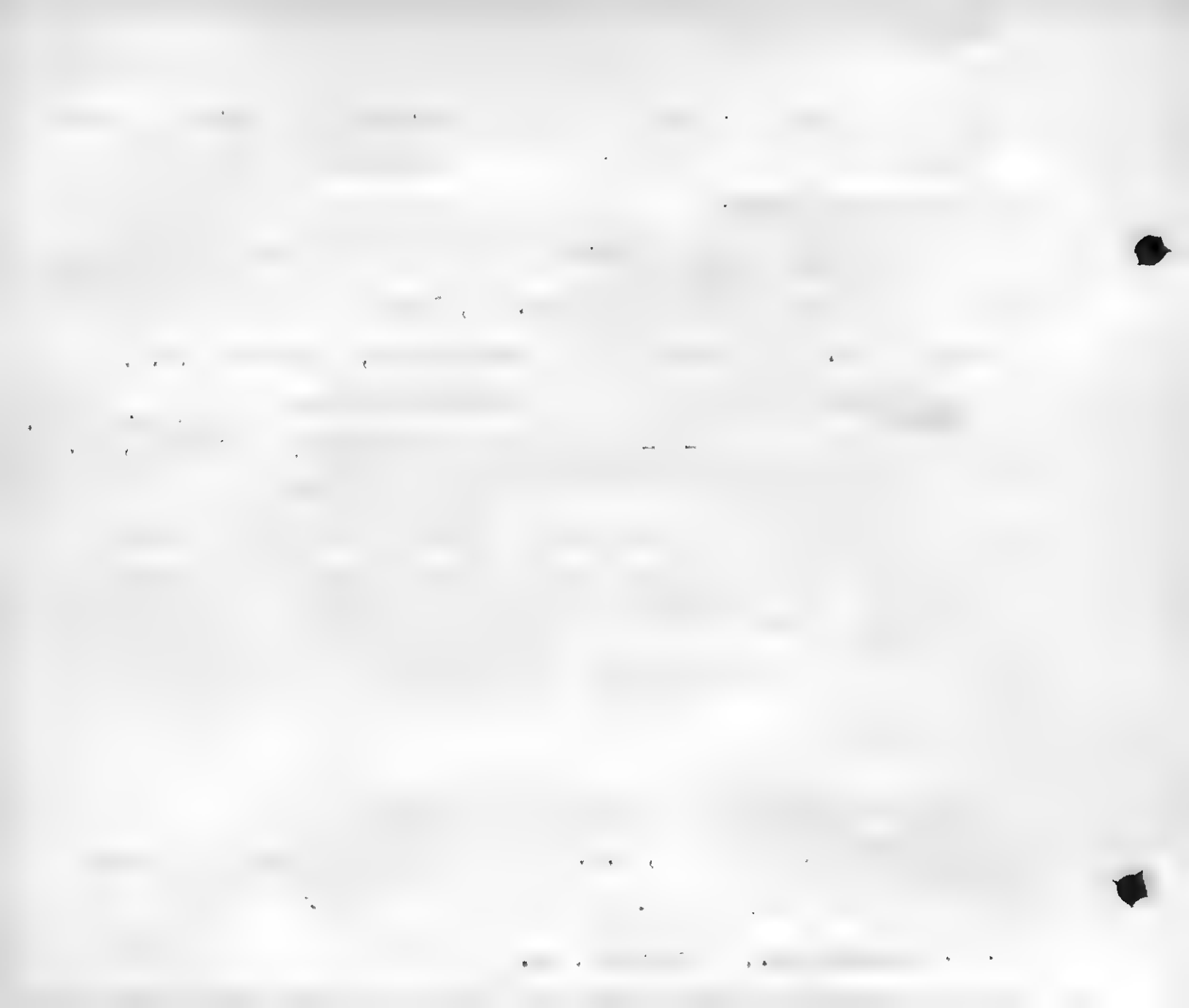
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and notify event within 72 hours after death.

02995

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04082

04983

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before) e. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN if outside of corporate limits write RURAL and give nearest town Suitland		c. CITY OR TOWN if outside of corporate limits write RURAL and give nearest town Suitland	
c. LENGTH OF STAY in 1b 50 Years		d. STREET ADDRESS 4604 Davis Avenue	
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address 4604 Davis Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN COLUMBIA SCHLORB		4. DATE OF DEATH Month Day Year April 25, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1889, 72 yrs.	
9. AGE in years last birthday 72		10. IF UNDER 1 YEAR Months Days Hours Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	
11. BIRTHPLACE (State or foreign country) Springville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Leonard Schlorb		14. MOTHER'S MAIDEN NAME Maryella Donaldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 17. INFORMANT 577-22-9780 Viola Marie Schlorb, Suitland, Md.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 120-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic Coronary Vascular disease - General Arteriosclerosis (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. None		INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown Unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Natural Causes	
20c. TIME OF INJURY Month Day Year Hour a.m. None p.m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul C. Van Natta		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-30-62	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA,	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR APR 30 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN
c. LENGTH OF STAY IN It
d. NAME OF HOSPITAL OR INSTITUTION
e. IS RESIDENCE ON A F. D. M?
f. AGE (In years last birthday)
g. AGE (In years last birthday)
h. AGE (In years last birthday)
i. AGE (In years last birthday)
j. AGE (In years last birthday)
k. AGE (In years last birthday)
l. AGE (In years last birthday)
m. AGE (In years last birthday)
n. AGE (In years last birthday)
o. AGE (In years last birthday)
p. AGE (In years last birthday)
q. AGE (In years last birthday)
r. AGE (In years last birthday)
s. AGE (In years last birthday)
t. AGE (In years last birthday)
u. AGE (In years last birthday)
v. AGE (In years last birthday)
w. AGE (In years last birthday)
x. AGE (In years last birthday)
y. AGE (In years last birthday)
z. AGE (In years last birthday)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04984

1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN Cheverly
c. LENGTH OF STAY IN It DOA
d. NAME OF HOSPITAL OR INSTITUTION Prince George's Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince George's
c. CITY OR TOWN East Riverdale
d. STREET ADDRESS 5301 Quintana St.

3. NAME OF DECEASED (Type or print)
First Middle Last
RAYMOND PHILLIP SHACKLEFORD

4. DATE OF DEATH April 13 1962

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH July 5, 1920
9. AGE (In years last birthday) 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Fireman
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Berryville, Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Mervin Howard Shackleford
14. MOTHER'S MAIDEN NAME Lula Mae Smallwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
16. SOCIAL SECURITY NO. W.W. II 229-34-7630
17. INFORMANT Christian Scholly 6006 BlackFires Cir. Baltimore, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia
(b) Drowning
(c) Drowning
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In an automobile that ran off the bank of the river
20c. TIME OF INJURY Month, Day Year 4:15 p.m. 4/13/1962
20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River
20f. (City or town) Queen Ann Bridge P. G. Md. (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd
EXAMINER'S NAME (Type) JAMES I. BOYD
22a. BURIAL CREMATION REMOVAL (Specify) Burial
22b. DATE THEREOF 4/17/62
22c. NAME OF CEMETERY OR CREMATORY Green Hill
22d. LOCATION (City, town, or country) Berryville, Va.
23. FUNERAL DIRECTOR F. Gasch's Sons
ADDRESS Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE APR 18 '62
24b. REGISTRAR'S SIGNATURE William S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04988

CERTIFICATE OF DEATH

Reg. Dist. No. 04985

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5120-38th AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle SIEGEL Last SIEGEL				4. DATE OF DEATH Month APRIL Day 16 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1884	9. AGE (in years last birthday) 77^{1/2} yrs	IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min. 16	IF UNDER 24 HRS. Months 7 Days 16 Hours 16 Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GETCHELL				14. MOTHER'S MAIDEN NAME RIVA MARCUS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-32-7335		INFORMANT OSCAR SIEGEL		Address FT. LAUDERDALE, FLA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, CEREBRAL DUE TO ARTERIOSCLEROSIS, GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 MONTHS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from JAN 1, 1967 to APRIL 16, 1967 , that I last saw the deceased alive on APR. 16, 1967 and that death occurred at 1 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Sugar M.D.				ADDRESS (Street, city or town, state) 4637 EASTERN AVE		DATE SIGNED 4/16/67	
PHYSICIAN'S NAME (Type) SAMUEL J. SUGAR				WASHINGTON 18, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/17/67		22c. NAME OF CEMETERY OR CREMATORY NATH. MEM. PARK		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA	
23. FUNERAL DIRECTOR'S SIGNATURE Lucas J. Kessel Home				ADDRESS 4217-9th NW		24a. REC'D BY REGISTRAR APR 17 1967	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(I)

(C)

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL) c. LENGTH OF STAY IN 1b 1 yr. 9 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 701 - E. Capitol e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Glenn Dale Myrtle B. Slagle		4. DATE OF DEATH Month Day Year April 19 19 62	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1896 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 13. FATHER'S NAME George O. Loving		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Carolina, Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. Decedent 17. INFORMANT Sarah Dishman Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with decompensation 420.0 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis; Generalized arteriosclerosis with chronic brain syndrome. INTERVAL BETWEEN ONSET AND DEATH 3 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1960, to April 19, 1962, that (I) last saw the deceased alive on April 19, 1962, and that death occurred at 7:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF April 27 - 62 23c. NAME OF CEMETERY OR CREMATORY Loving Family Cem. Harrotons Va. 23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR DATE APR 30 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04991

04988

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO d. STREET ADDRESS ROUTE #4, BOX 1094 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRIAN THORNTON SMITH		4. DATE OF DEATH Month Day Year APRIL 2 19 62	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 MARCH 1962
9. AGE (In years last birthday) yrs. Months Days 2 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MARYLAND		12. CITIZEN OF WHAT COUNTRY UNITED STATES	
13. FATHER'S NAME DELBERT THORNTON SMITH		14. MOTHER'S MAIDEN NAME CAROLYN ANN CRAIG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DELBERT T SMITH (FATHER)		Address SAME AS ITEM #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (b) BRAIN DAMAGE (a), stating the underlying cause last. (c) FRACTURED SKULL		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 48 HOURS 48 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CRANIOTABES		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SKULL FRACTURE INCURRED DURING SPONTANEOUS DELIVERY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9:59 AM MARCH 31, 1962		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USAF HOSPITAL	
20f. (City or town) ANDREWS AFB, PRINCE GEORGES, MD		20g. (County) PRINCE GEORGES	
20h. (State) MD		20i. (City or town) 31 MARCH	
20j. (County) 19 62		20k. (State) 2 APRIL	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 MARCH 19 62 to 2 APRIL 19 62 , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on 2 APRIL 19 62 , and that death occurred at 1030P from the causes and on the date stated above.		22a. SIGNATURE John A Moore M.D. 22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAF MC	
22b. DATE SIGNED 2 APRIL 1962		22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/6-1962	
23c. NAME OF CEMETERY OR CREMATORY ARL NAT CEMETERY ARLINGTON VA		23d. LOCATION (City, town or county) WASH	
23e. ADDRESS WASH		23f. CITY OR TOWN ARLINGTON VA	
23g. STATE VA		23h. ZIP CODE 22204	
24. FUNERAL DIRECTOR'S SIGNATURE Will Chambers Co 517-11th St SE (3) DC		25a. RECEIVED BY REGISTRAR DATE APR 6 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Pinner		25c. DATE APR 6 '62	

2-1-8362



13
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04992
04991
MAYLAND STATE DEPARTMENT OF HEALTH
OFFICE OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write nearest and give nearest town) Washington d. STREET ADDRESS 1417 Holbrook Street N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. DATE OF DEATH April 16 19 62 g. AGE (If years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min h. BIRTHPLACE (State or foreign country) Virginia i. CITIZEN OF WHAT COUNTRY? U. S. A.	
3. NAME OF DECEASED (Type or print) Clarence William Southard 4. SEX Male 5. COLOR OR RACE White 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. DATE OF BIRTH August 5, 1899 62 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 9. KIND OF BUSINESS OR INDUSTRY Oil Burner 10. FATHER'S NAME Columbus Benjamin Southard 11. MOTHER'S MAIDEN NAME Laura Virginia Wheakley		12. WAS DECEASED EVER IN U.S. ARMED FORCES? no 13. SOCIAL SECURITY NO 578-07-7563 14. INFORMANT Anna Cecilia Southard, same as # 2	
15. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Acute congestive heart failure (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary artery disease- severe (c) Cardiovascular renal disease		16. INTERVAL BETWEEN ONSET AND DEATH	
17. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED April 17, 1962		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-20-62 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 22d. LOCATION (City, town, or county) Washington, D.C. 22e. ADDRESS W.W. Chambers Co. Riverdale, Md. 22f. REC'D BY REGISTRAR APR 19 '62 22g. REGISTRAR'S SIGNATURE William S. Evans	



1
FOR STATE
HEALTH DEPT.

04993

DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04989

1 PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (if outside co. pc
write RURAL and give nearest town)

MARYLAND

c. LENGTH OF STAY IN IN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)

Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution; Residence of decedent if not)
a. STATE

Maryland

b. COUNTY

Prince Georges

Laurel

d. STREET ADDRESS

606 Main Street

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

W. DOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan. 10, 1957

9. AGE (in years
last birthday)

5

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10b. KIND OF BUSINESS OR INDUSTRY

Child

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lewis Paul Sproles

14. MOTHER'S MAIDEN NAME

Thelma M. Dunsmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

None

None

16. SOCIAL SECURITY NO.

Mr. Lewis P. Sproles, Laurel, Md.

Address 606 Main St.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

INTRACRANIAL INJURY and FRACTURE PELVIS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Struck by truck in street

20c. TIME OF INJURY Month Day Year

2:00 April 24, 62

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

500 Blk. Main St. Laurel, Maryland.

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion
death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

PAUL C. VAN NATTA, M.D.

CHIEF MEDICAL EXAMINER ☐

22. ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

4/25/62

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/28/62

22c. NAME OF CEMETERY OR CREMATORY

Sharon Masonary

22d. LOCATION (City, town, or country)

Howard Co., Md.

(State)

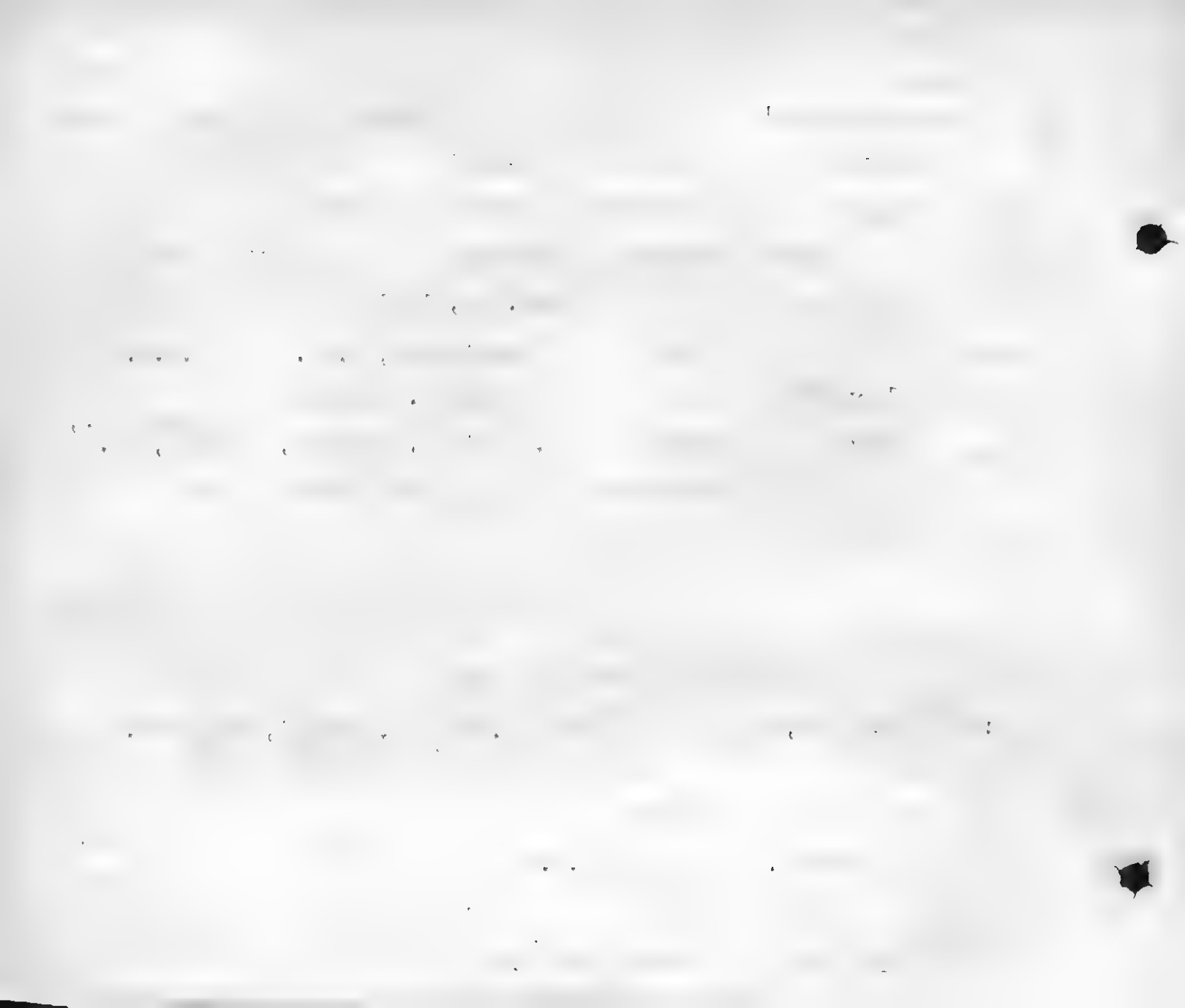
23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE APR 30 '62

Arthur S. ...



VR A15 {4}
ISM 7/61

Maryland Ave.
Ittsville, Md.

Arthur P. Kane



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04932

1. PLACE OF DEATH
a. COUNTY Prince Georges Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Myattville
c. LENGTH OF STAY IN b 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Myattville, Md.
d. STREET ADDRESS 625 Sheridan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Fern Middle Edith Last Jacobson
4. DATE OF DEATH Month April Day 22 Year 1962
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Jan 20 - 1890
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS., last birthday) 72 yrs. Months 12 Days 22 Hours 19 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME Albert Carson 14. MOTHER'S MAIDEN NAME Johnna Kilbuck
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Marion Petrick Address 1422 Quaker St. Fort Myattville, Md.

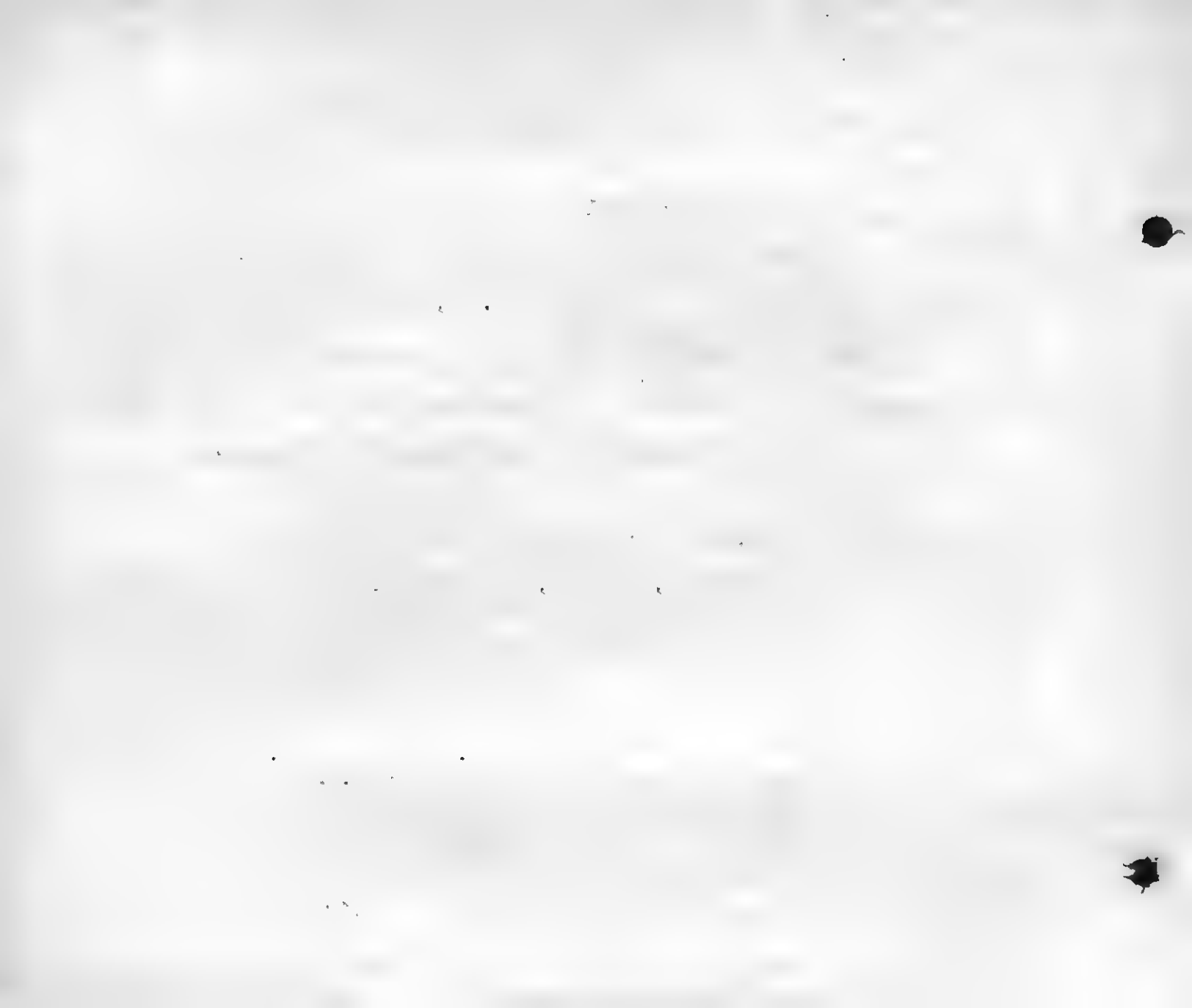
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous
DUE TO Carcinoma left breast
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10/2, 1958, to 4/22, 1962, that (I) (we) last saw the deceased alive on 4/21, 1962, and that death occurred at 2:00 P.M. from the causes and on the date stated above.
22a. SIGNATURE M. F. Ottman
22b. DATE SIGNED 4/22/62
22c. PHYSICIAN'S NAME (Type) M. F. OTTMAN
22d. ADDRESS 401 Kennedy St. NW DC
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF April 25 - 1962 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery 23d. LOCATION (City, town, or county) (State) Washington, D.C.
24. FEDERAL DIRECTOR'S SIGNATURE Arthur Helton ADDRESS 254 Carroll St. DC 25a. REC'D BY REGISTRAR — 25b. REGISTRAR'S SIGNATURE — DATE APR 24 '62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04936 CERTIFICATE OF DEATH 04933

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 46 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt Rainier d. STREET ADDRESS 4526 32nd S t., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Guiseppe Vincelli		4. DATE OF DEATH Month Apr. Day 22 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1930
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer for Whelan Co.		11. BIRTHPLACE (County & State, or foreign country) Campobasso, Italy	
13. FATHER'S NAME Michele Vincelli		14. MOTHER'S MAIDEN NAME Mariantonio Pietrantonio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 578-50-1463		16. SOCIAL SECURITY NO. 578-50-1463	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple perforations and fistulae of large and small intestine DUE TO (c) Adhesions, multiple, post-surgical		INTERVAL BETWEEN ONSET AND DEATH 1 Week Weeks Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 7, 1962 , to Apr. 22, 1962 , that (I) (we) last saw the deceased alive on Apr. 21, 1962 , and that death occurred at 12:35 A.M. the causes and on the date stated above.			
22a. SIGNATURE John H. Bayly		22b. DATE SIGNED APR 26 '62	
22c. PHYSICIAN'S NAME (Type) JOHN H. BAYLY		22d. ADDRESS 1835 Eye N.W., WASH D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/25/62	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City, town or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Kalley's Funeral Home		25a. REC'D BY REGISTRAR APR 26 '62	
ADDRESS 3100 Rd. and		25b. REGISTRAR'S SIGNATURE William S. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04907
04954
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write nearest town) Chesverly c. LENGTH OF STAY IN b. 7 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 510 68th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold First E Middle Walker Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 7, 1900 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		4. DATE OF DEATH Apr. 10 19 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworking 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Edward Walker 14. MOTHER'S MAIDEN NAME Mary Frances Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 183-5 17. INFORMANT Mrs Pauline Walker-wife 510-68th ave Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Pneumonia left upper lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 wks DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic Carcinoma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/3/62 , 19 62 , to Apr. 10 , 19 62 , that (I) (we) last saw the deceased alive on 5:30 P.M. , 19 62 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.	
22a. SIGNATURE George William Ware 22c. PHYSICIAN'S NAME (Type) Dr. George William Ware		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1835 Eye St NW, Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-13-62 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Suitland, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS Washington DC 25a. REC'D BY REGISTRAR Apr 13 1962 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
4
04998
M
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04995

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City, Md.		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3708 38th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eue Middle Wallin Last Wallin		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1890
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME L. P. A. Wallin		14. MOTHER'S MAIDEN NAME Louisa M. Frickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Elvira W. Greenwood same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic congestive failure 410X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio & mitral valve disease DUE TO (c) hypertensive cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above			
22a. SIGNATURE George J. Hageage M.D.		22b. DATE SIGNED 5/21/62	
22c. PHYSICIAN'S NAME (Type) Dr. George J. Hageage		22d. ADDRESS 3717 38th Ave., Cottage City, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		24. ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE MAY 4 '62		25b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04999 **CERTIFICATE OF DEATH** 04996

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 35--Maryland Ave. S. E.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland d. STREET ADDRESS 35--Maryland Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) REV. ROBERT L. WHITTENBURG				4. DATE OF DEATH April 17th 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1882	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas A. Whittenburg				14. MOTHER'S MAIDEN NAME Mary E. Whitehurst			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1201			
17. INFORMANT Sarah M. Whittenburg -35 Maryland Ave Md.				Address Parkland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Coronary atherosclerosis DUE TO (b) General Arteriosclerosis DUE TO (c) none of note PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none of note				INTERVAL BETWEEN ONSET AND DEATH Instant unknown unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) natural causes			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1962 to Apr. 17, 1962 that (I) (we) last saw the deceased alive on Apr. 16, 1962 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Paul C. Van Natta				22b. DATE SIGNED April 17th 1962			
22c. PHYSICIAN'S NAME (Type) Dr. Paul C. Van Natta				22d. ADDRESS 5440--Silver Hill Rd., Suitland Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 20, 1962		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION (City, town or county) (State) Forestville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661--Good Hope Rd., SE Washington 20 DC				25a. REC'D BY REGISTRAR APR 19 62		25b. REGISTRAR'S SIGNATURE Christina L. Pinner	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a physician or other person authorized by the State Department of Health. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

05000

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04997

1. PLACE OF DEATH
a. COUNTY **Prince George County** MARYLAND
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN b. **D.O.A.**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Prince George Hospital**
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Prince George**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Forestville**
d. STREET ADDRESS **5419 Pine Street**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) **Ralph Allen Williams**
4. DATE OF DEATH **April 27, 1962**
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **March 27, 1912** 9. AGE (in years last birthday) **50** yrs. IF UNDER 1 YEAR: Months Days Hours M'n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Bus Operator** 10b. KIND OF BUSINESS OR INDUSTRY **D.C. Transit** 11. BIRTHPLACE (State or foreign country) **Washington, D.C.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**
13. FATHER'S NAME **George A. Williams** 14. MOTHER'S MAIDEN NAME **Mary Alice Spell**

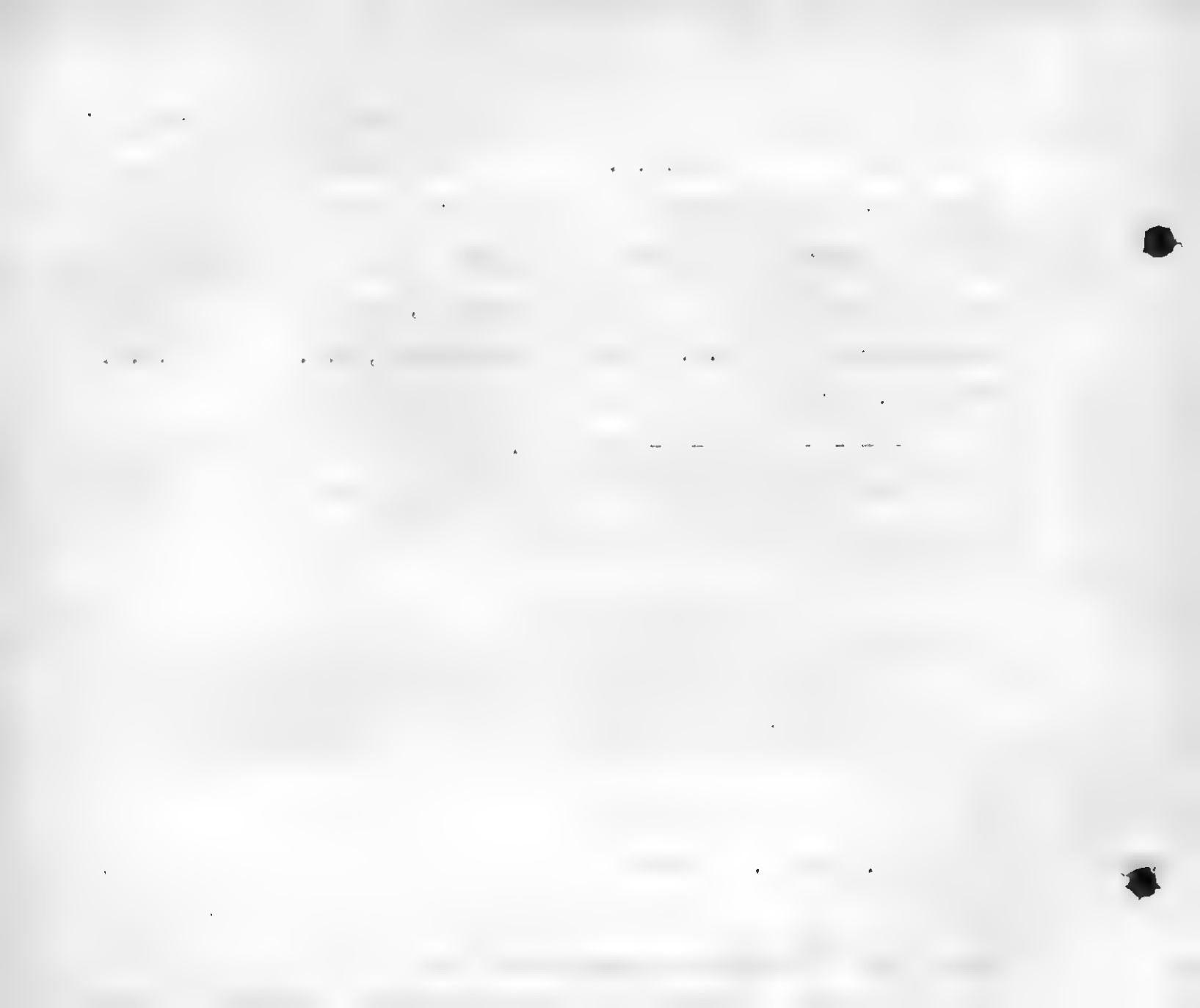
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **578-10-7358** 17. INFORMANT (Wife) Address **Mrs. Doris Williams - Same as 2d**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Acute Coronary Occlusion**
DUE TO (b) **Coronary Artery Disease**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) **Unknown**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **natural causes**
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **at home** 20f. (City or town) **Forestville** (County) **Prince George** (State) **MD**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE **Paul C. VanNatta** M.D. DATE SIGNED **April 27, 1962**
EXAMINER'S NAME (Type, **Dr. Paul C. VanNatta** Address (Street, city, town, or county) **Forestville, Prince George County, MD**

22a. BURIAL, CREMATION, or REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4-30-1962** 22c. NAME OF CEMETERY OR CREMATORY **Fort Lincoln** 22d. LOCATION (City, town, or country) **Prince George County, MD**
23. FUNERAL DIRECTOR **Robert A. Mattingly** ADDRESS **131-114 St. Wash D.C.** 24a. REC'D BY REGISTRAR **APR 30 '62** 24b. REGISTRAR'S SIGNATURE **Arthur L. Howard**



1
FOR STATE
HEALTH DEPT.

05001

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04938

1. PLACE OF DEATH
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN b

Cheverly DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF DECEASED
(Type or print)

Walter Lanier Wilson Jr

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 11, 1942

9. AGE (In years last birthday)

20 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Barber

10b. KIND OF BUSINESS OR INDUSTRY

Barber

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Lanier Wilson Sr.

14. MOTHER'S MAIDEN NAME

Helen Margaret Curtin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-40-9534

17. INFORMANT

Walter Lanier Wilson Sr., same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Hemorrhage and shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Crushed skull

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Passenger in an automobile that overturned

20c. TIME OF INJURY

Hour

12:30xx

Month, Day, Year

4/3/62

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (factory, street, office bldg., etc.)

Road

20f. CITY OR TOWN

Lanham P. G.

(County)

(State)

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

EXAMINER'S NAME (Type)

James I. Boyd

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

4/3/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-6-1962

22c. NAME OF CEMETERY OR CREMATORY

Mt Olivet Cemetery

22d. LOCATION (City, town, or country)

Washington, D.C

23. FUNERAL DIRECTOR

W. W. Chambers 80 Riverdale, Md

24. REC'D BY REGISTRAR

APR 6 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Hines

TO THE CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

05002

04939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) e. STATE Maryland f. COUNTY Prince Georges County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS R.F.D. Box 3703	
3. NAME OF DECEASED (Type or print) Harrison Wade Windsor		4. DATE OF DEATH Month April Day 8 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-99
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WINDSOR		14. MOTHER'S MAIDEN NAME AGNES WINDSOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 215-14-7127	
17. INFORMANT Wilson Windsor, Upper Marlboro, Md.		18. INTERVAL BETWEEN ONSET AND DEATH Chronic	
1b. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Pulmonary Edema Conditions, if any, which gave rise to immediate cause (b) 2. Congestive Heart Failure (c) 3. Left Coronary Thrombosis (fresh) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from... 4-3-1962, to... 4-8-1962 that (I) (we) last saw the deceased alive on... 4-8-1962, and that death occurred at 5:50 P.M. the causes and on the date stated above.			
22a. SIGNATURE Clark Holmes 22c. PHYSICIAN'S NAME (Type) Clark Holmes		22b. DATE SIGNED 4/9/62 M.D.	
22d. ADDRESS Upper Marlboro		22e. ADDRESS Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY MC CARMEL		23d. LOCATION (City, town or county) (State) Upper Marlboro, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home, Maryland		25a. REC'D BY REGISTRAR APR 12 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



1
FOR STATE
HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05003
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05000

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7800 Largo Road	
3. NAME OF DECEASED (Type or print) Nellie M. Maria Windsor		4. DATE OF DEATH April 10 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Henry Roberson		14. MOTHER'S MAIDEN NAME Georgeiana (Last Name Unknown) Route # 3 Box 604E	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clarence Windsor Edgewater, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate (b) Cardiovascular renal disease (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Fracture of the right hip	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH Fell on the bed room floor	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home		20c. TIME OF INJURY Hour 1:00 Day 3/23 Year 4/24/1962	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Largo P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James L. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES L. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/62	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town or country) (State) Bladensburg Maryland	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro		24a. REC'D BY REGISTRAR APR 23 '62	
24b. REGISTRAR'S SIGNATURE Charles S. Thomas		DATE SIGNED 4/10/62	

05004

CERTIFICATE OF DEATH

05001

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY D C	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sutherland Nursing Home		d. STREET ADDRESS 14450 White Hall Street	
3. NAME OF DECEASED (Type or print) John Witt	4. DATE OF DEATH 4 25 1962	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Male	7. COLOR OR RACE white	8. DATE OF BIRTH 7-26-81	9. AGE (In years last birthday) 80 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer	11. KIND OF BUSINESS OR INDUSTRY Railroad	12. BIRTHPLACE (County & State, or foreign country) Pennsylvania	13. CITIZEN OF WHAT COUNTRY? U.S.
14. FATHER'S NAME John Witt	15. MOTHER'S MARRIED NAME UNKNOWN	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
17. SOCIAL SECURITY NO. 705-09-4266		18. INFORMATION Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, colon & generalized metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/11/62 to 4/25/62, that (I) (we) last saw the deceased alive on 4/25/62, and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Mugmon	22b. DATE SIGNED	22c. ADDRESS 3109 NICHOLS AVE SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-29-62	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Hill Grove Cemetery	23d. LOCATION (City, town or county) (State) CONNELLSVILLE, PENN.
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR DATE APR 27 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05005

05002

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 CAMP SPRINGS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5564-Branch Ave SE</u>				d. STREET ADDRESS <u>5564-Branch Ave SE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Romey</u> Middle <u>FRANKLIN</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>					
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-JAN. 1882</u>		9 AGE (In years lost birthday) <u>80</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas F. Wood</u>				14. MOTHER'S MAIDEN NAME <u>MIRIAM E. Burgess</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] 			16. SOCIAL SECURITY NO 		17 INFORMANT Address <u>FRANCES E. Wood - SAMEAS - 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> DUE TO <u>322X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asbestos mottled</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Natural causes</u>								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) _____ (County) _____ (State) _____		
21 I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> , 19 <u>62</u> to <u>Apr 3</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Apr 3</u> , 19 <u>62</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.									
22a SIGNATURE <u>Paul C Van Natta</u> M.D.								ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>								22d ADDRESS <u>5440 Silver Hill Rd Washington 28 D</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 6-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sammy Burt</u>				ADDRESS <u>1661- Good Hope Rd SE Wash. 20 D</u>		25a. REC'D BY REGISTRAR DATE <u>PR 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

22b. DATE SIGNED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 9 Film 3-11 4/25/62 mh											
05006											
CERTIFICATE OF DEATH											
Item 2 Film 3-11 4/25/62 mh											
Reg. Dist 05003											
1 PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE D.C.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Years				c. LENGTH OF STAY IN 1b 5 Years				d. STREET ADDRESS 2002 P St. N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL L. JOR (4922 LaSalle Rd)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) ELIZA P. WORTHINGTON				4 DATE OF DEATH APRIL 20 1962							
5 SEX F.		6 COLOR OR RACE W.		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH APRIL 26, 1865		9 AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days Hours Min 11 26	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY GEORGETOWN				11. BIRTHPLACE (State or foreign country) U.S.A.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES WORTHINGTON				14. MOTHER'S MAIDEN NAME REBECCA BRITTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. INFORMANT SISTER AGNES PATRICIA (CARROLL L. JOR)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH CON- gestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Nov. 15, 1958, to April 20, 1962, that I last saw the deceased alive on April 20, 1962, and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas F. Collins M.D. 322 H. St. N.W. April 20, 1962											
22a. BIRTH AL, (Specify)				22b. DATE THEREOF 4/23/62				22c. NAME OF CEMETERY OR CREMATORY Rock Creek			
22d. LOCATION (City, town, or county) Washington D. C.											
23. FUNERAL DIRECTOR'S SIGNATURE Joe. G. ...				24a. REC'D BY REGISTRAR DATE APR 23 '62				24b. REGISTRAR'S SIGNATURE L. S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05007

05004

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE d. STREET ADDRESS CONCORD AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ADOLPH			4. DATE OF DEATH Month APRIL Day 29 Year 19 62		
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 AUGUST 1923	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (County & State, or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME unknown			
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES 1943-1962			
16. SOCIAL SECURITY NO. 017-18-5555		17. INFORMANT Address Records Andrews A.F. Base			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 936.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. FRACTURED SKULL AND INTRACRANIAL HEMORRHAGE DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ALLEGEDLY INVOLVED IN ALTERCATION					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour 6:30 p.m. Month, Day, Year APR 29 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) TAVERN	
20f. (City or town) BALTIMORE		20g. (County) BALTIMORE		20h. (State) MD	
21. I certify that (I) XXXXXX attended the deceased from 29 APRIL 19 62 to 29 APRIL 19 62 , that (I) XXX last saw the deceased alive on DOA 19 62 , and that death occurred at 845P , from the causes and on the date stated above.					
22a. SIGNATURE Kenneth G. Grigg M.D.			22b. DATE SIGNED 29 APRIL 1962		
22c. PHYSICIAN'S NAME (Type) KENNETH A GRIGG, Capt USAF MC			22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD		
23a. BURIAL CREMATION, REMOVAL (Specify) SHIP		23b. DATE THEREOF 5-1-62		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town or county) PANAMA CITY FLA		23e. REC'D BY REGISTRAR DATE MAY 3 '62			
23f. REGISTRAR'S SIGNATURE Arthur L. Kline		23g. REGISTRAR'S SIGNATURE			

10000

10000

(M)

FRANCIS BROWN

ADDRESS AT BOSTON

HE AIR FORCE OFFICE

ARMY

CAUCASIAN

ARMY

HE AIR FORCE

FRANCIS BROWN

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FRANCIS BROWN

ARMY & NAVY IN ASSOCIATION

APR 22 1902

NAVY

BALTIMORE

FOR

FOR

APR 22 1902

ARMY & NAVY IN ASSOCIATION

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the County Health Officer or the County Health Officer's designee. The County Health Officer should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 4 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 East Riverdale d. STREET ADDRESS 5509 59th Avenue	
3. NAME OF DECEASED (Type or print) Joseph Ignatz Zmayuski		4. DATE OF DEATH April, 18 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Plant maintenance Lithuania	
13. FATHER'S NAME Adam IX Zmyuski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Joseph Julius Zane, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct DUE TO (b) Phlebotrombittis DUE TO (c) Fracture of right hip		INTERVAL BETWEEN ONSET AND DEATH 36 hrs 2 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis, congestive heart failure			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in yard of home	
20c. TIME OF INJURY Month, Day, Year 4/14/62 Hour a.m. 8:15 xxx		20d. INJURY OCCURRED Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) East Riverdale (County) P. G. Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-1962	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or country) Bladensburg, Maryland	
23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Maryland		24a. REC'D BY REGISTRAR APR 23 1962	
24b. REGISTRAR'S SIGNATURE Chas. A. Harris		DATE April 18, 1962	

